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Research Thesis for the Degree of Doctor of Philosophy in Law

# LEGAL AND REGULATORY ISSUES OF ELDERLY CARE IN ENGLAND

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Michael Stephen Keeler

March 2015

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## **DEDICATION**

To my late mother, Bridget Keeler, whose advancing dementia and other health issues caused the family to yield her care to the care home system (and who died rather suddenly of suspected care home neglect); and to my late father, Hugh Keeler, who benefitted from the domiciliary care delivery system (overseen by the writer who lived next door) until successive strokes and associated rehabilitation leaving him in need of constant wheelchair assistance, caused the family to surrender him to a far better care home than my mother. Both parents selflessly facilitated my access to modern education opportunities not available to their generation.

## **DECLARATION**

I, Michael Stephen Keeler, declare that this thesis is my own original work and that it has not been presented and will not be presented to any other University for a similar or any other degree award

Signature: .....

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## ABSTRACT

Elderly care is one of the more high profile contemporary issues that confronts care professionals, the Government and its citizens. Central to these are concern how care is best regulated and the cost effectiveness of decisions to cut care delivery across the public and private sectors. Defining what constitutes good care delivery is a continuing challenge to health care managers and staff, as the benchmark is in constant flux due to advances in modern medicine and the progression of new and dangerous ill-health conditions. Culture, personal values and expectation changes from generation to generation also blur the definition of what constitutes good care. This thesis offers a contemporary analysis of care and examines how regulatory systems have been too *ad hoc* and often retrospective; leading to deficiencies in the pro-activity and holistic response elderly care requires to tackle its issues. This is one of the most rapidly evolving areas of regulation in a period of intense media attention and public concern over elderly care. A considerable degree of permanence can be identified towards the action plan of the Government in engaging a variety of reactionary regulatory strategies.

In the later analysis in the thesis, it is suggested that additional specialist and dedicated regulation may still prove to be necessary to secure care quality and undertake preventative measures against the abuse of this vulnerable section of the community. Public concern and medical interest continues to reveal cases of severe neglect of the elderly in many private care homes. The Care Quality Commission, the main regulator since 2009, undertakes inspections and reports on care quality, but doubts remain as to how effective the measures in place guard the quality of care in practice. The second Francis Report on the Mid Staffordshire NHS

Foundation (5<sup>th</sup> February 2013) highlighted many failings in the National Health Service and showed how the most vulnerable and elderly to be particularly at risk. Reports of poor care of the elderly continue to confirm that stricter monitoring and inspections are needed.

The aims and objectives of this thesis, are to understand how elderly care regulation has addressed systemic regulatory failures and provides a case study of lessons learnt from past omissions and mistakes. At the time of writing, the Care Quality Commission has undertaken tougher inspection regimes by currently adopting a system of special measures, and new regulations are being considered. Over its approximately six years of activity since it 'plugged a regulatory hole' it's now progressively much improved inspectorate function has even just embraced 'whistle-blowing' as part of its 'work in progress' profile. There is continued pressure on the regulator to meet expectations of ensuring high quality care, and it is also a response to the changing role of care homes; reflecting the diverse range of care and the ageing population.

This thesis provides an analysis of how elderly care has evolved over many centuries and varied in its standards of delivery. Defining appropriate levels for care standards is one approach, adopting a holistic approach is another, but the culture of care is one that needs to be fostered through family members who are often engaged in the delivery of elderly care, as well as the community at large. Developing care through purely legal mechanisms, such as the setting of care standards has its limitations, but will undoubtedly also feature as part of any perceived solution. There are signs that the changing culture in care homes and those that provide care, is a recent and most welcome shift in regulatory goals and objectives. It is argued that this change reflects positively on the current care system

which has been driven by some better education of care workers and greater empathy with the elderly; an empathy which is driven by the growing reality with every new generation that most of us will live well into our elderly years due to the advancement of modern medicine.

Reflected also is increased lack of trust in people, where in the past assumptions about care delivery standards by individuals were relied upon instead, and how to engage with the continuous re-design of oversight regulatory structures issues of legitimacy and increasing public trust.

The Care Quality Commission is developing its own identity and offers a form of social regulation that is set apart from the main economic regulators. There are many lessons which can be learnt when working from within the National Health Service through the use of internal networks, access to current government policy and funding arrangements. Despite strong ministerial engagement in this area, the Care Quality Commission has been able to maintain its own voice and, in recent months, has developed its expertise to address public concerns about elderly care. Despite this, the statistics show that at least one third of care homes are regarded as less than satisfactory, suggesting that much work remains to be undertaken. Coordinating clinical and social care of the elderly is part of patient safety. It also connects with regulating the professional standards of health and social care professionals.

Michael Keeler: March 2015.

## CHAPTER 1: Introduction

### 1.0 Introduction

The starting point of the thesis is to define its points of reference and the main research question addressed. The main focus of the thesis, is on how elderly care in contemporary British society is regulated under English law. Devolved administrations have health care as a devolved matter but broadly follow the example of England and are subject to similar social and economic care issues as are other parts of the United Kingdom.<sup>1</sup>

The main research question is how effectively elderly care is regulated in light of contemporary concerns about the standards and failings in elderly care delivery in many care homes. This is a neglected area of study and the role of regulation of elderly care is too often overlooked by lawyers and regulatory specialists. It is one of the fastest growing areas of regulation where reports of failures in elderly care delivery have led to the re-design in the regulatory responses.

Care of the elderly is a useful case study in the general context of the regulation of social care, and is an example of the continuous redesign required to enable regulatory structures to meet new challenges. The current regulator from January 2009 is the Care Quality Commission (CQC) which replaced the Healthcare Commission and the Commission for Social Care Inspection. The CQC covers registration of all aspects of health and adult social care providers covering National Health Service Trusts and private care homes.

Although the CQC has been in existence for only five years, this has proved to be a transformative period for how elderly care is regulated. A brief mention is

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<sup>1</sup> See: Nicholas Timmins, *The Four UK health systems* The King's Fund, 2013.

required of Monitor, the independent regulator of NHS Foundation Trusts that accompanies their establishment. It works closely with the CQC in terms of financial matters associated with NHS Foundation Trusts and operates a complementary licensing and registration system. Monitor is to ensure that patients and taxpayers are protected by well managed foundation trusts.

The history and development of the regulatory system will be outlined in some detail in the thesis. Recent reports about abuse in some care homes have raised concerns about poor regulation.<sup>2</sup> This has led to the strengthening of care home regulation, and increases the regulator's powers and duties. The Care Act 2014 has just been passed with the purpose of making elderly care more effective. The regulation of this kind of care is likely to dominate agendas for most of this century.

The terminology in use throughout the thesis is itself the subject of debate. Broadly speaking 'regulation' can be taken to refer to "the sustained and focussed attempt to alter the behaviour of others according to defined standards or purposes with the intention of producing a broadly identified outcome or outcomes, which may involve mechanisms of standard- setting, information gathering and behaviour modification."<sup>3</sup>

'Accountability', particularly much debated as a term, can conveniently in the British system be "found in a range of arrangements for what may be broadly called 'democratic oversight' ".<sup>4</sup>

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<sup>2</sup> *Care workers found guilty of abusing dementia patients*-Press Association-The Guardian (28 November 2013)- "Three care workers have been found guilty of mistreating dementia sufferers...Preston Crown Court heard". *Essex care home worker arrested on suspicion of assaulting elderly patient*- Press Association - The Guardian (3 May 2014).

<sup>3</sup> *Critical Reflections on Regulation*- LSE Centre for the Analysis of Risk and Regulation Discussion Paper 4 (2002)- Julia Black.

<sup>4</sup> *Regulation, Democracy, and Democratic Oversight in the UK: The Regulatory State- Constitutional Implications* (Oxford; Oxford University Press , 2010) – Dawn Oliver.

‘Transparency’ in the context of the carrying out or performance of regulatory functions is broadly understood as ‘open to public oversight’, but some academic assistance of this concept can perhaps be gained from the comments “criticisms of the regulatory agencies as inherently unaccountable are now heard far less often....partly due to the regulators themselves; aided by new legal duties, they have generally adopted a highly transparent approach to their work. Indeed their transparency has been greater than that of traditional government departments.”<sup>5</sup> This directly reflects the transition in the last three decades from ministries of government having direct control and oversight to non-ministerial institutions (NMI’s) and independent regulatory agencies (IRA’s), particularly in healthcare.

The term ‘regulator’ in the context of the thesis can accordingly be understood to be the individual or body exercising regulatory functions.

It is clear from the thesis that the experience of elderly care regulation provides some useful regulatory lessons about the flexibility of regulation and developing an important social role under intensive and unprecedented public scrutiny and political debate. The National Health Service funding and delivery raises issues about health care for the elderly in a period of austerity, and the growth of the elderly proportion of the population.

Elderly care provision is having to expand to meet the demographics of an ageing population at a time where the UK has a substantial public debt. Although the National Health Service has been protected from general public sector cuts of over 40%, the increasing demands made by elderly care have to be addressed. Concerns about the quality of elderly care have been identified in recent health care provision. The Robert Francis QC Report in 2013 is the most important in recent years

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<sup>5</sup> *Models of Economic and Social Regulation- The Regulatory State: Constitutional Implications* (Oxford; Oxford University Press 2010) – Tony Prosser.

because of its findings of systemic failure at Stafford Hospital and exposed serious failings relating to care of the elderly amongst other failings; and in some cases, neglect contributed as a cause of death. The report has resulted in the re-ignition of an on-going debate as to why there were so many failures and what should be appropriate regulatory re-engagement with the issues exposed in the report.<sup>6</sup> Regrettably, the Francis Report is consistent with other reports into elderly care.<sup>7</sup> It speaks of systemic weaknesses in care delivery as well as in care regulation.

It is apparent that the regulatory failures discussed in the Francis Report are most serious for those that were most directly affected, being a case study of regulatory oversight failure. This has served to create new directions and re-designs of existing regulatory mechanisms. This engages with the public as well as the politicians and Parliament.

At the heart of the issues raised by Francis is the need to put the patient at the centre of care delivery, as discussed by Tony Prosser, a public law academic,<sup>8</sup> who focussed on Sir Ian Kennedys vision in this respect. Prosser further advocates the need for social solidarity approaches to care regulation by bodies such as the principal regulator the Care Quality Commission (CQC) and its legitimacy in its link to the Health Secretary, both being accountable to Parliament. This structure supports the need to engage the public's perception of the need for trust and effectiveness. The complexities of care regulation well beyond the economic regulatory model, says Prosser, carry public accountability and legitimacy lessons for other forms

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<sup>6</sup> Report of the Mid Staffordshire NHS Foundation Inquiry, 6 February 2013, chaired by Robert Francis QC (HC 947).

<sup>7</sup> *The state of Healthcare and Adult Social Care in England-2013/14* Care Quality Commission-15<sup>th</sup> October 2014 HC691- "We have found some outstanding care...We have also found services that are inadequate or require improvement...The public is being failed by the numerous hospitals, care homes and GP practices that are unable to meet the standards"-Foreword-page 2.- [www.cqc.org.uk](http://www.cqc.org.uk)

<sup>8</sup> Tony Prosser – *The Regulatory Enterprise(2010)* Oxford:Oxford University Press- Chapter 6- The Care Quality Commission and its Predecessors.



within the regulatory community, including the degree of CQC operational independence required.

Julia Black has identified a number of contributory causes that may ultimately lead to real improvements in regulation and regulatory bodies<sup>9</sup>. These include varieties of trust and accountability structures, the system of communication and addressing weaknesses or ambiguities and contradictions, regulating complex systems that may need simplification and setting incentives to encourage individual prudence.

In many ways the aftermath of the Francis Report and its consequences are likely to continue to be far reaching and they are far from settled as the long term implications for elderly care are being gradually progressively addressed.

### 1.1 Elderly care in contemporary Britain: an overview

In recent years the management and delivery of health care in England has undergone changes and these changes are on-going. Primary care trusts, strategic health authorities and the NHS executive have been replaced by clinical commissioning groups (CCGs). These are led by general medical practitioners (GPs), and the creation of NHS England as a new national commissioning group to oversee GPs and set conditions under the Health and Social care Act 2012, allowing for greater competition. Monitor acts as an economic regulator and licences and regulates NHS Foundation Trusts. Perhaps surprisingly many of these changes began with the 1999-2010 Labour Government and have been continued under the Coalition government led by the Conservative Party. Much GP commissioning is being organised through primary Health Care Trusts<sup>10</sup>.

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<sup>9</sup> Julia Black, *Learning from Regulatory Disasters* LSE Working Paper 24/2014 pages 4-5.

<sup>10</sup> See: Nicholas Timmins, *The Four UK health systems* The King's Fund, 2013

Elderly care involving a stay in an NHS hospital is available for both chronic and acute cases. One estimate is that a total of 80% of those who stay in hospital stay longer than 14 days and are over 65.<sup>11</sup> Emergency stays in hospital, and failures in care delivery at home may adversely impact on the elderly more than any other sector. Indeed pre-mature discharge from hospital and poor follow up by the GP may also impact on elderly patients more than most sectors of the population. Long-term medical conditions may flair up and this may also cause hospital admission. The King's Fund has estimated that "around 6 million people in the UK are unpaid carers<sup>12</sup>" and it is not surprising that increasingly carers are older citizens who may themselves be struggling with illness.

Local authorities provide support to informal carers within families with general information and advice. There are limited funds for respite care and also to allow carers to buy some services. In England, formal systems of care are available, sometimes paid for by the local authority or by the user of the services. These include home care that helps adults with caring tasks and needs, day care that allows some form of respite care for informal carers and care homes that are funded by a variety of funding mechanisms including local authority and families of relatives or the elderly person out of their own funds.<sup>13</sup>

The range of local authority elderly care direct provision of help or advice on where to obtain things extends across a large spectrum from wheelchairs, hoists and grab-rails, extra care housing, and telecare electronic monitoring of a person in their own home with an alarm system.

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<sup>11</sup> David Oliver and others, *Making our Health and Care systems for an ageing population* The King's Fund, 2013 p.33.

<sup>12</sup> See David Oliver and others, *Making our Health and Care systems for an ageing population* p.11.

<sup>13</sup> NAO Report, *Adult Social Care in England : Overview* HC 1102 Session 2013-14 ( 13<sup>th</sup> March 2014).

Support for local authority powers is to be found in the Care Act 2014 with a new safeguarding duty on local authorities and a duty on local authorities to manage local care markets and the taking into account of the “well-being of the patient.” The Care Act for the first time requires local authorities to take steps to safeguard vulnerable adults against abuse or neglect. Much of the Act is expected to come into force in April 2015.

More generally, local authorities are important in the delivery of various forms of general care and today have been charged with a statutory duty under the Health and Social Care Act 2012<sup>14</sup> to improve public health. Preventative measures, especially for the over 65 age group are seen as essential to the strategy of improving health in the elderly. A key element of the Act is the establishment of Health and Wellbeing Boards as statutory committees of upper tier local authorities which came into effect on 1<sup>st</sup> April 2013.

The Boards are a blend of community action and local health care initiative fused into local authority led forums aimed to improve public health and well-being of the people in their area, reduce health inequalities and promote the integration of service. The Boards are to provide public health commissioning support and guidance to the Clinical Commissioning Groups set up under the NHS reforms. NHS England is the primary organisation that sets out the terms of reference, duties and powers of the Health and Wellbeing Boards who are given responsibility to undertake needs assessment in their area.

The Boards are also included in consultation procedures and draft plans as well as having a jurisdiction to object to a plan and make representations to NHS England. The Boards act within a general statutory framework that provides for

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<sup>14</sup> (2012, c.7).

systems of accountability and representation. There are elected representatives on the Board, and the Boards' are subject to local authority scrutiny procedures. The *Adult Social Care and Public Health Outcome Frameworks* and additional guidelines issued by Public Health England to facilitate the parameters of local authority activities and the levels of their achievements in delivering their public health outcomes.<sup>15</sup>

The role of an independent consumer watch-dog Healthwatch at local level it provides a complaints advocacy service and also may monitor quality standards and their delivery. Although this is not an inspectorate as such, local Healthwatch groups are expected to liaise with the Care Quality Commission, the official regulator, as part of the overall regulation. Section 12 of the Health and Social Care Act 2012 provides a new duty on local authorities to take appropriate steps to improve the health of the people living in their area but subject to the Secretary of State having overall responsibility for national public health functions.

Powers given to local authorities are extensive. They include undertaking research and information dissemination on health diets, and exercise regimes. Financial incentives can be targeted to individuals to adopt a healthier life style and also targeting individuals to help minimise risk arising from their accommodation or poor housing, grant awarding powers may be used. Detailed arrangements for health checks for eligible citizens are also provided including advice services and a comprehensive document *A Public Health Toolkit for Local Authorities in England* is available and provides general governance and clinical guidance. The King's Fund, a well-known and highly regarded think tank, observed that multiple funding streams, complexity over commissioning arrangements, fragmentation into clinical

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<sup>15</sup> Public Health England, *An Introduction to the Public Health Outcomes Framework for England 2013-16*

commissioning groups rather than population based health budgets will make integration more difficult to achieve:

*The NHS in England, like its counterparts in other developed countries, is facing two major, interlinked challenges: an increasingly frail older population with complex care needs, and public health problems associated with unhealthy life styles. Addressing these challenges requires a more integrated approach to commissioning across public health, health care and social care- something that present and previous governments in the United Kingdom have acknowledged.*<sup>16</sup>

As will be developed throughout the thesis, there is a well- recognised “crisis” over elderly care in Britain.<sup>17</sup> The crisis arises because of the current numbers of people aged over 65 and predictions that the numbers are likely to increase. Based upon the 2011 Census, the Office for National Statistics (ONS) predicts that in England in 2021 there will be 24% more people aged 65 and over and 39% more people aged 85 and over. Projected to 2030 therefore the ONS states that, compared with 2010, there will be 51% more people aged 65 and over, and 101% more people aged 85 and over.<sup>18</sup>

There is also some uncertainty over the exact predictability of demographic statistical projections from census data. This is not a comparatively easy and straightforward exercise. There are many variables. For example in the 2020-2030 decade 10.7 million people in Britain can currently expect inadequate retirement

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<sup>16</sup> The King’s Fund, *Improving the allocation of healthcare resources in England*, April 2013 p.15. cited and discussed in House of Commons Library, *Local authorities’ public health responsibilities* ( England) SN06844 ( 13<sup>th</sup> March 2014).

<sup>17</sup> *Care in Crisis* – [www.ageuk.org/Care\\_in\\_Crisis](http://www.ageuk.org/Care_in_Crisis). Joseph Rowntree Foundation - *The Crisis in UK Care- issues affecting care homes* – [www.jrf.org.uk/Care-Home-Crisis](http://www.jrf.org.uk/Care-Home-Crisis).

<sup>18</sup> ONS –Interim 2011-based sub-national population projections: local authorities, counties, regions and England: single years of age, persons. ([www.ons.gov.uk/population](http://www.ons.gov.uk/population)).

incomes;<sup>19</sup> by 2018 in England there will be 50% more people with three or more long term health conditions,<sup>20</sup> and by 2030 there will be 80% more people aged 65 and over with dementia (moderate or severe cognitive impairment) in England and Wales compared to 2010.<sup>21</sup>

On demographic trends, the social care of the elderly is included in the findings of the King's Fund Review undertaken by Sir Derek Wanless in 2006, *Securing Good Care for Older People* (2006).<sup>22</sup> Estimates are that:

*...by 2026, 1 in 5 of the population will be aged 65 or over and the number reaching 85 will have grown by two thirds. Their needs related to age will also grow with higher levels of care required...the direction of policy in many local authorities is in developing private elderly care as well as public care. The allocation of resources to those most in need has the effect of leaving gaps in the care arrangements for a middle group.*<sup>23</sup>

There are differing opinions<sup>24</sup> over the reliability of economic statistics in an EU free movement of person's context, making it difficult to predict the scale of the use of UK elderly care.<sup>25</sup> A number of points emerge from the discussion on the demography of elderly care. First is that elderly care numbers are subject to change. It is too difficult to predict the overall total but it is likely to increase; second that elderly care includes the treatment and early diagnosis of chronic conditions- such

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<sup>19</sup> Department for Work and Pensions – (July 2012) – Estimates of the number of people facing inadequate retirement incomes. ([www.dwp.gov.uk](http://www.dwp.gov.uk)).

<sup>20</sup> The Kings Fund – supplementary evidence- Report (14 March 2013) of the House of Lords Select Committee on Public Service and Demographic Change – Ready for Ageing? HL 140.

<sup>21</sup> Professor Carol Jagger, Newcastle University, - evidence to the House of Lords Report (14 March 2013) *ibid*

<sup>22</sup> [www.kingsfund.org.uk/projects/wanless-social-care-review](http://www.kingsfund.org.uk/projects/wanless-social-care-review) and *Department of Health response to Care Act consultation*- The Guardian (Ruth Hardy)- 23 October 2014- "Many consultation responses, in particular those from local government, highlighted concerns about adequate funding for social care...the government has changed its estimates to reflect a larger number of potential recipients...rising to an additional £100m per year".

<sup>23</sup> Wanless 2006 Report – *ibid*-p99.

<sup>24</sup> Michael Hill (2006) *ibid* p99.

<sup>25</sup> Michael Hill (2006) *ibid* p99.

as dementia, Parkinson's disease or late onset diabetic conditions- are likely to place considerable demands on the National Health Service.

The implications of the need for the chronically ill to be treated also gives rise to considerable room for debate in the UK as well as across Europe with serious implications for each country.<sup>26</sup> European migration flows are one collective issue, but other European perspectives such as problems with integrated care delivery in Sweden, Italy and Germany are discussed in section 1.5 of this chapter.

It is evident from one leading academic Michael Hill's analysis that the impact of an elderly ageing society on social policy will need to be closely monitored including the tracking of demographic change its relationship to economic policy and its direct impact on social policy.

*"It is important to make this a comparative analysis since, even in the societies where this ageing process is quite marked; there are different rates of change, with potentially different implications. If an economic template of sorts was thought to be achievable as an extension of this discussion, that is dependent on whom in society can be observed and from quite recent evidence that proposition is a complex situation in itself."*<sup>27</sup>

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<sup>26</sup> *Migration Flows of A8 and other EU migrants to and from the UK*- April 2014-"This briefing discusses migration of European Union...citizens (excluding British citizens) to and from the UK...The accession of East European countries (A8 countries) to the EU in 2004 lead to a significant increase in the inflow of EU citizens to the UK. The average annual Long-Term International Migration (LTIM) inflow of EU citizens (excluding British citizens) for 2004-2012 was around 170,000, compared to 67,000 during 1997-2003". [www.migrationobservatory.ox.ac.uk-10](http://www.migrationobservatory.ox.ac.uk-10). In France the 2010 report – *Long Term Care in France* (June 2010)- European Network of Economic Policy Research Institutes (ENEPRI) – Marie-Eve Joel and others examines the detail of central and local Department government care delivery and its challenges. This Report is discussed in more detail in Chapter 4 (end of Paragraph 4.3) of this thesis. Broad similarities with England are remarkable.

<sup>27</sup> Michael Hill – *ibid*. For example – 'Living independently and well' – and other conclusion in the Report by the House of Lords Select Committee (14 March 2013) - *ibid*.

Economic analysis of OECD or UN figures<sup>28</sup> may also provide a useful indication of future trends.<sup>29</sup> But here there are questions over what it means to be classified as “dependant” and is that person so identified a source of government cost; and whether it matters in the overall scheme of things whether high levels of economic dependency are problematic.<sup>30</sup> It is clear that predicting the long-term number of elderly care patients is likely to be difficult.

It is also clear that improvements in hygiene and health care, and standards of living generally, have increased amongst the elderly in our society. This has a number of aspects: the rising cost of health care for the elderly;<sup>31</sup> the provision of care homes and their regulation; and challenges in respect of the chronically ill such as, for one example, those suffering dementia.<sup>32</sup> Accompanying these changes are cultural and expectation changes from one generation to another.

## 1.2 Elderly care and the financial crisis

In the UK it is a remarkable fact that a large proportion of elderly care is regularly delivered by friends and family members<sup>33</sup> and this makes it difficult to

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<sup>28</sup> For example those projecting those aged 20-64 as a percentage of those aged over 65 (United Nations 2003 data).

<sup>29</sup> Seriously challenged by the conclusions in the House of Lords Report, *Ibid*.

<sup>30</sup> For example, it is obvious that the very existence of increased care need through longevity is drawing an increased care delivery industry. Also, their funding often derives from the elderly person’s own earned pension ‘pot’ or from the sale of their assets such as a house, and even private and commercial assets from which the elderly person derived a rental income.

<sup>31</sup> Respected commercially acquired information being periodically available at [www.laingbuisson.co.uk/marketreports/data](http://www.laingbuisson.co.uk/marketreports/data).

<sup>32</sup> Itself a single word which introduces a wide spectrum of mental disability, projected to expand rapidly as a condition – (Professor Carol Jagger, Newcastle University [above]). “Each year, more than 900,000 people with dementia attend NHS hospitals and 150,000 of those spend an average of 13 days as inpatients – nearly three days longer than similar people without dementia”- Daniel Allen: Royal College of Nursing Bulletin (May 2014-issue no.315). One severely demented patient in Birmingham Heartlands Hospital is recently reported to have waited an additional 2 months there awaiting a suitable care home placement – ‘Protecting our patients’ BBC2 (1 May 2014).

<sup>33</sup> Apparently arising from post-Reformation necessity, and certainly recognised as such in the Statute for the Relief of the Poor 1601 (43 Eliz. 1, c.2) part of which provided that parents and their children were responsible



define the remit of public service support with any precision,<sup>34</sup> but also increasingly via private limited care companies. Michael Hill has also shown that the public private mix of providers is a striking shift in responsibilities:<sup>35</sup> the number of elderly care providers in the independent sector amounts to at least 96% and is further examined in detail in Chapter 8.<sup>36</sup>

The current role of the local authority, apart from providing visiting care to persons in their own homes, is to find local authority or private or voluntary or charity sector home provision for those in need of care homes, provided that the local authority is either meeting the total cost of such care, if they meet the financial criteria, or are partially or fully self- funding.<sup>37</sup>

To put the picture in greater perspective, it is stated that 45% of all care home residents are fully self-funded and that in July 2005, 88% of residents were paid for by a local authority whilst in independent sector homes, compared with 82% in 2000 and 20% in 1993.<sup>38</sup> Also, the enormous shift of elderly care provision to the private “for profit” sector has itself inherently challenged the ability of regulatory oversight in terms of financial stability issues, commercial considerations driving shareholder profit ambitions.

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for each other, so poor elderly parents were expected to live with their children” – [www.elizabethan-era.org.uk/the-poor-law](http://www.elizabethan-era.org.uk/the-poor-law). Also, *The generation Strain: Collective solutions to care in an ageing society*-(Clare McNeil, Jack Hunter)-(24 April 2014)-Institute for Public Policy Research (IPPR)- “Most care for older people is not provided by the state or private agencies but by family members, at an estimated value of £55 billion annually”. [www.ippr.org/publications](http://www.ippr.org/publications). Supported by *The Changing Face of Retirement* Carl Emmerson and others-(June 2014)-Institute for Fiscal Studies- at paragraph 3.4-‘Care Provision’-page 29.

<sup>34</sup> Even with the extensive compilation by the Institute for Fiscal Studies (IFS) of its own and Office for National Statistics (ONS) data, as in the June 2014 Report- *IBID*.

<sup>35</sup> In *Social Policy in the Modern World (2006)* – *ibid*.

<sup>36</sup> The state of healthcare and adult social care in England in 2011/2012 ([www.cqc.org/reports](http://www.cqc.org/reports)) – inclusive of a small percentage of voluntary sector and charity sector providers the number 4 was not shown in this report.

<sup>37</sup> Figures provided at ([www.ageuk.org/carehomes](http://www.ageuk.org/carehomes)) but the local authority role is about to be enlarged to all elderly needing care – Section 9 Care Act 2014 (2014, c.23).

<sup>38</sup> CQC Report *Ibid*. – ([www.cqc.org/reports](http://www.cqc.org/reports)). However, the Care Act 2014 Section 9 has extended the local authority advice role to all persons in need of elderly residential care.

There are a number of aspects of elderly care that need to be addressed in the context of the financial crisis of 2008 and the general reduction of public service provision, but NHS spending for elderly and other care has been afforded some protection from budget cuts. This protection does not apply to social care delivery through district nursing and related support systems via local authorities, and councils total spending on adult social care in the three years since the 2010 spending review fell by 8 per cent in real terms. Older adults aged 65 and over have experienced the greatest reduction, 12 per cent in real terms.<sup>39</sup>

In the three years since April 2010, local authorities' spending on individual packages of adults care services of home care, care homes with and without nursing, and day care has fallen significantly. Around three-quarters of the reduction in local authority spending has been through reducing the amount of care provided. Volumes of care have fallen across all types of care service.<sup>40</sup>

A recent National Audit Office (NAO) report warned of the consequences of financial cuts to adult health care,<sup>41</sup> an important authoritative 'modern snapshot' of the UK system. The NAO stated:

*"The longer term trend of reducing the amount of care provided has continued, but NAO analysis shows that local authorities have also improved their ability to control their costs in delivering core services since 2010-11."*

*"Paying lower fees to independent sector providers of care can put pressure on their financial sustainability."*

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<sup>39</sup> Sourced from National Audit Office Report (13 March 2014): 'Adult Social Care in England: An Overview'. Report by the Comptroller and Auditor General HC 1102 Session 2013-14 – Para 1.37.

<sup>40</sup> NAO Report – *Ibid* - Para 1.39

<sup>41</sup> NAO Report *Ibid*. - [www.nao.org.uk/press-releases](http://www.nao.org.uk/press-releases) (p.1).

*“The NAO warns that, while the Department of Health and the Department for Communities and Local Government are working together to understand the cumulative implications of changes to, and reduced spending on, health and social care, welfare and related services, other departments are not.”*

The NAO Report recognises that “most care and support is provided unpaid by family, friends and neighbours, while many adults pay for some or all of their formal care services.”<sup>42</sup> “Local authorities provide a range of universal and preventative services”<sup>43</sup> and “legislative and other changes are increasing adults’ role in shaping their own care and support.”<sup>44</sup>

It concludes that adult care needs are rising; adults with long-term and multiple health conditions and disabilities are living longer, and that local authorities’ total spending on adult care fell 8 per cent in real terms between 2010-11 and 2012-13 and is projected to continue falling. The Report highlights the need to instigate systemic improvements with elderly persons’ poor experiences from the lack of “joined up” care when using the NHS and social services. The full impact of the economic recession linked to public spending cuts calls into question the continuing provision of social care. Britain and other European states face resource accountability questions.<sup>45</sup>

These concerns about the wider implications of public spending cuts are important. Despite ring fencing the NHS, the financial crisis has had a major impact on the delivery of public services and in the provision of many aspects of care. This

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<sup>42</sup> For example the Care Quality Commission. The NAO’s head is the Comptroller and Auditor General, an officer of the House of Commons pursuant to the National Audit Act 1983 (1983, c.44) who reports to Parliament of his own volition and free of political control – [www.nao.org.uk/about-us](http://www.nao.org.uk/about-us).

<sup>43</sup> National Audit Office, ‘Adult Social Care in England’, Report by the Comptroller and Auditor General, 13 March 2014 (p.5, Section 2).

<sup>44</sup> *Ibid* p.5 Section 5.

<sup>45</sup> NAO Report *Ibid*.

is likely to continue. In the past between 1948 and 2009 spending on education, health and social security rose by an average of 4.5% annually in real terms, as The Economist noted: “the present Government is in the midst of an unprecedented state-pruning exercise...almost all the entire surge in spending that occurred under Labour’s Tony Blair and Gordon Brown [1997-2010] have been reversed....The NHS still treat more people with less money. Everything else has been slashed.”<sup>46</sup> It may be concluded that there are long term implications for the UK in terms of all aspects of social welfare provision as the full extent of the crisis has yet to be estimated. As will be explained in the thesis regulating elderly care has to take into consideration the main social and economic context of the financial arrangements for health care in general. It also has to ensure that there are adequate arrangements for accountability over the main care providers.

### 1.3 Historical perspectives on elderly care

As will be developed in more detail in Chapter 2, the history of elderly care in England is a legacy originating from medieval Christian times and impacted by other religious and secular influences.<sup>47</sup> Perhaps, unsurprisingly, there was little public regulation of clinical or social care standards during these times.

Understanding the complexities of today’s healthcare structures is impossible without examining historically from where they are derived, particularly where some historic organisations have their modern counterparts.

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<sup>46</sup> The Economist – 9 November 2013. P.15.

<sup>47</sup> The Ancient Greek and Roman philosophical influences on contemporary care delivery are discussed by Professor Roger Crisp, Oxford University, including stoic ethics from Athens as one of the then four main ancient Greek schools of philosophical thinking, alongside that of Plato, in his *Homeric Ethics* Chapter 1 contribution of his editorship of *The Oxford Handbook of the History of Ethics* (31 January 2013) Oxford: Oxford University Press- along with many other academics who discuss Christian and other influences on these issues.

That legacy is about the giving of care by individuals or small organisations of individuals, to patients. It was almost certainly locally organised and often as a result of caring for the poor and elderly. Their underlying values and the extent to which those values have influenced our care-giving standards today remains a fundamental question, especially when market or commercial considerations are involved as they are today.<sup>48</sup> It is also clear that friends and family performed major social care roles- particularly with elderly parents.

Care influenced by a wide range of religious and secular philosophies, and widely held, and practised, Catholicism in the early medieval period was suddenly confronted by the event of State seizure of control over religious worship, and in particular its monastic care delivery structures. The word “elderly” or its more common predecessor (in some respects) “aged” or “old-aged” had contradictory meanings. At one extreme it could imply a “cursed by God” label on many of the then smaller number of people who lived long enough. This is an extension of the lepers referred to in the Old Testament being considered by others as being “cursed by God” for some wrong they, or their parents, were perceived to have committed.<sup>49</sup> This attitude does not fit easily with helping the poor or the less fortunate.

Post-Reformation religious structures and beliefs emerged. In contemporary times transforming ultimately into a non-religious secular society. State intervention through regulating charities came about in reality as early as the 16<sup>th</sup> Century, and a sea-change took place in 1834.<sup>50</sup> The NHS emerged in the 1950s with the further

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<sup>48</sup> In “*Persons and Potentiality: An Aristotelian Approach*” – *Bioethics, Ancient Themes in Contemporary Issues* (2000) – Cambridge, Mass: MIT Press , at pages 155-177, Professor Christopher Megone, Professor of Interdisciplinary Applied Ethics, Leeds University, demonstrates further support for the Ancient Greek and other philosophically informed linkage to modern care ethics.

<sup>49</sup> Book of Numbers 12: 9–12 – Miriam cursed by God for speaking against Moses. A perception which increasingly spread in Christian communities in Medieval Times – [www.kenyon.edu/projects](http://www.kenyon.edu/projects)

<sup>50</sup> And arguably earlier, but in these middle ages culminating in the Elizabethan Statute for the Relief of the Poor 1601 (43 Eliz.1, c.2) – providing the framework for the poor law for the next 350 years, and effectively a

historical philosophical influences of many, but in particular Bentham,<sup>51</sup> Chadwick,<sup>52</sup> Lloyd-George and Beveridge<sup>53</sup> accompanying a further surge of state legislative provision. In this latter context, it has become a reiteration of political and social vertical and horizontal power, and also an empowerment.

The Royal Society for the Prevention of Cruelty to Animals and its history<sup>54</sup> (and royal patronage: not conferred on the 'equivalent' human organisation, the National Society for the Prevention of Cruelty to Children)<sup>55</sup> remind us that animal care also has a long history, with state intervention, and it is clear that over the years the human and animal care systems have learned from each other.

Historical factors set the scene. The two world wars were a major influence. The Victorian era also left its legacy. Social, economic, political and generational cultural change led to huge demographic challenge by virtue of longevity, with the absence now of war and disease as population depletion agents, a component of which is arguably attributable to the very success of the NHS as a concept.

In 1942, the Beveridge Report set a new standard for national health supposedly to embrace in a universality sense the entire needs of the community, but without provision specifically for the non-hospitalised elderly as a category of that community. Modern demography proffers the explanation that even his forward projections could not foresee today's volumes of elderly care need.

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parish based local government structure for much of those years; When the Poor Law Amendment Act 1834 (4 & 5 Wm.4, c.76) abolished centuries of entitlement to be relieved and imposed the stigmatised workhouse system.

<sup>51</sup> Discussed by S.E. Finer in *The Life and Times of Sir Edwin Chadwick* (1997) London: Routledge/Thoemmes Press.

<sup>52</sup> S.E. Finer *Ibid.*

<sup>53</sup> Discussed by D. Frazer in *The Evolution of the British Welfare State; A History of Social Policy since the Industrial Revolution* (2003) Basingstoke: Palgrave Macmillan Publishing; culminating in Beveridge's case in his Report to Parliament (1942) - Social Insurance and Allied Services (Cmd. 6404) His Majesty's Stationery Office, London.

<sup>54</sup> [www.rspca.org.uk/history](http://www.rspca.org.uk/history).

<sup>55</sup> [www.nspcc.org.uk](http://www.nspcc.org.uk)

To what extent is this vision valued today? Was his dream of enhancing the health of the nation too successful over time? Can the state afford not to play the paterfamilias role whatever the challenges are of this hybrid role? If it can afford to, should it? Increasing privatisation in all but name, but perhaps paradoxically, increasing expectations that the state will provide care amidst rising standards.

The post-war consensus in the wake of the 1946/1948 major legislation being implemented has triggered the most comprehensive and wide ranging debate,<sup>56</sup> made more urgent and high profile by reason of the Coalition Government formulating emergency policies to meet the severest economic and financial challenges ever encountered.

Several centuries of 'building blocks' for today's charities, and other institutions call for detailed analysis.

As will be clear from the thesis, one of the emerging concerns from a review of historical cases is that abuse has largely remained "behind closed doors," or covered up.<sup>57</sup> One reason is the one to one relationship basis for each elderly person, possibly including an elderly culture of not wanting to complain. Another reason is that the religious status of the care giver provided a margin of discretion based on the assumption that their behaviour is unchallengeable as it is provided by a servant of God. Contemporary evidence from media reports demonstrates that it may not be possible to know the extent to which exploitation of the elderly went

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<sup>56</sup> Not least the most holistic one so far invited by the House of Lords Select Committee on Public Service and Demographic Change Report – *Ready for Ageing?* (14 March 2013) – HL Paper 140.

<sup>57</sup> Granny Battering – G.R. Burston – *British Medical Journal* (1975); 3: 592.

unnoticed and the difficulties remain in identifying the extent of exploitation which remains in the care service today.<sup>58</sup>

One reason for an increase in the elderly in care is as a result of raising life expectancy. This is a 20<sup>th</sup> century phenomenon. At the beginning of the Welfare State in July 1948, the then UK life expectancy for males at birth was 65.8 years, and for females 70.1 years, and each of those figures by even 2006 had then increased respectively to 76.9 years for males and 81.3 years for females.<sup>59</sup> Development of life expectancy has a continuous impact on continuing policy formulation. The same dynamics that have led to a higher proportion of older people in the population has also yielded a steady rise in expectation of life at birth and at later ages. Expert evidence examining these issues recently identified two principal methods to predict future life extensions: period life expectancy and cohort life expectancy, resulting in further complexity in this area.<sup>60</sup>

Nevertheless, care of the elderly in this jurisdiction is still primarily a family responsibility. Equally important is the application of charitable status to many private organisations in the delivery of elderly care and private trusts. Each of these has remarkably old historic roots, as does the modern justice of the peace who in the middle ages formed part of a local government system involved in care delivery.

One of the remarkable shifts is from public to private sector delivery which began in the 1990s. This occurred under the NHS and Community Care Act 1990

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<sup>58</sup> *Care workers found guilty of abusing dementia patients*-Press Association-The Guardian (28 November 2013)-“Three care workers have been found guilty of mistreating dementia sufferers...Preston Crown Court heard”.

*Essex care home worker arrested on suspicion of assaulting elderly patient*- Press Association- The Guardian (3 May 2014).

<sup>59</sup> [www.bbc.co.uk/news/1/hi/health-](http://www.bbc.co.uk/news/1/hi/health-) sourced from the Office for National Statistics (ONS) 2006 data.

<sup>60</sup> See evidence given to the House of Lords for its report *Ready for Ageing?* (14 March 2013) by the Select Committee on Public Service and Demographic Change (Session 2012-2013)-HL Paper 140 pages 20/21 also sourced from ONS statistical bulletin, *Life expectancy at birth and at age 65 by local areas in the United Kingdom, 2004-06 to 2008-10*, 19. October 2011, p16.



that allowed private nursing residential and home care could be paid by the Department of Health and Social Services.

#### 1.4 The aims and objectives of the thesis on regulating elderly care

The primary focus of the thesis is on the regulation of elderly health care in contemporary Britain. Regulation takes account of associated issues relating to the social, economic and legal ones surrounding health care delivery and care of the elderly.

There is ample statistical analysis in the UK and in many developed countries highlighting demographic and elderly population projections from the present time until about 2050. This has been the context of what has become known largely journalistically as a “demographic time bomb.” There are clear dramatic consequences in terms of the economic, fiscal, and societal impact for elderly care.<sup>61</sup> There is also the serious and growing problem of the relentless rise in chronic disease among the elderly. Michael Hill, a leading social policy researcher in this field, suggests that addressing all these issues associated with elderly care funding has to be adequate and this is dependent on those that are in employment supporting the elderly.<sup>62</sup> Hill argues that:

*...it is important to recognise that it is the pattern of labour market participation rather than the demographic profile in each country that needs primary attention. Furthermore, even use of this more accurate index of dependency*

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<sup>61</sup> For example – *Pension Trends* – 14 May 2010 (Office for National Statistics), *Pensioner Poverty over the Next Decade; What Role for Tax and Benefit Reform* July 2007 (The Institute for Fiscal Studies) (IFS), *Living Standards, Poverty and Inequality in the UK: 2012* (IFS, Joseph Rowntree Foundation and Economic & Social Research Council).

<sup>62</sup> *Social Policy in the Modern World – A Comparative Text* – Michael Hill (Blackwell Publishing 2006) – Chapter 12 – ‘Ageing Societies.’

*can lead us into economistic thinking where only people who are economically active are perceived as making contributions to society.*<sup>63</sup>

A recent review of studies in the USA and Europe focussed upon a statistical fact that physical challenges to less educated people with manual jobs caused them largely to promptly take available retirement, but that more older people with higher degrees were evidently remaining in the workforce, and concluded that “...a growing group of highly educated older folk could increase productivity, offsetting much of the effect of a smaller workforce,” the latter being a negative effect feared by economists with ageing western societies.<sup>64</sup>

Generally health care, including elderly care, was given little public regulation until recent times. This is because many regulatory issues were embedded in the form of personal care delivered by friends or family. Institutional elderly care delivery came from religious organisations or affiliated institutions. In terms of medical delivery, this was the responsibility of many professional bodies and organisations that were subject to specific registration and licensing requirements. There are no less than nine competent bodies with a wide variety of responsibilities and duties.<sup>65</sup>

Very often care responsibilities are linked to disciplinary rules and regulations. In this context, one of them, the General Medical Council (GMC) already

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<sup>63</sup> Michael Hill *Ibid.*

<sup>64</sup> *Briefing : Demography, growth and inequality –Age invaders – The Economist* (26 April 2014) sourcing data from *The big shift* (2014) UN Population Division and *American labor force participation for men and women aged 62-74 by level of education* – Gary Burtless, Brookings Institution (2014).

<sup>65</sup> The subject of an entirely separate government sponsored Law Commission review which reported with a draft reform Bill in Spring 2014 recommending a single unified statute and then autonomy to accommodate each professional body’s own separate identity – *Regulation of Health and Social Care Professionals*-(2 April 2014)- On 29 January 2015 the Government accepted the large majority of the recommendations in full and others in part – [www.lawcommission.justice.gov.uk/areas/Healthcare\\_professions](http://www.lawcommission.justice.gov.uk/areas/Healthcare_professions).

modified its disciplinary proceedings in 2000 to pre-empt statutory intervention after criticism of its self-regulatory accountability weaknesses;<sup>66</sup>

Even with professional bodies and organisations within the NHS there were few explicit regulatory obligations setting standards of care and their attainment. It is clear that recent publicity given to successive regulatory failures of elderly care homes has attracted considerable attention. Media attention is naturally linked to any negative and catastrophic news events rather than stories of success. Nevertheless elderly care has attracted a great deal of criticism especially amidst horrific reports of bad practice.<sup>67</sup>

In fact much of the funding for private care comes from public funds such as for care home and domiciliary visiting areas.<sup>68</sup> However, private sector investment there in the last two decades dwarfs what the public sector could have achieved.

As will be outlined in the thesis, the development of care quality is a working progress. In the mid-1990s, the Department of Health began to take more interest in monitoring performance of the market in health care. The internal market was one motive as private care providers were permitted to receive public funds in care homes.

With local authority homes themselves the late 1970's and early 1980's was also a period of neglect for such homes in terms of physical standards and often in terms of quality of care. These deficiencies were exposed by the rapid development

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<sup>66</sup> In the wake of Dr Harold Shipman being jailed as a serial killer in January 2000 – [www.gmc.org/FTP.reforms](http://www.gmc.org/FTP.reforms) and [www.bbc.co.uk/TheShipmanReports](http://www.bbc.co.uk/TheShipmanReports).

<sup>67</sup> For example – *Care home worker jailed for abuse of 89 year old* -Helen Nugent – The Guardian (29 August 2012).

<sup>68</sup> Particularly demonstrated by the case *YL v Birmingham City Council* [2007] UKHL 27 where Southern Cross, a private limited company to whom the Council had delegated by contract its National Assistance Act 1948 statutory duties was ruled by the House of Lords not to engage Human Rights Act public body protection; – soon changed for future purposes by Parliament enacting Section 145 of the Health and Social Care Act 2008 (2008, c.14). But for over half a century since the passing of the National Assistance Act 1948 (1948, c.29) witnessing daily private care delivery with public funding.

of independent sector residential and nursing home care in the 1980's and the associated passing of the 1984 Registered Homes Act.<sup>69</sup>

The 1984 Act<sup>70</sup> recognised the need to structure a growing private sector of accommodation which paralleled an existing nursing home system, where the boundaries between the two were not always clear and required regulatory oversight.<sup>71</sup> Private home expansion was itself stimulated by local authority home closures rather than such authorities trying to financially resource facility upgrades in times of great budgetary constraint.

The Law Commission in 1983 had been requested to examine the Government's stated purpose to continue to assimilate legislation relating to residential care homes and the then legislation relating to nursing homes, respectively the Health and Social Services and Social Security Adjudications Act 1983<sup>72</sup> and the Nursing Homes Act 1975,<sup>73</sup> in respect of which the proposed consolidating statute under consideration had raised technical inconsistencies.

The new statute provided for compulsory registration, standards and inspection of residential care homes as a new category<sup>74</sup> a similar structure for nursing homes,<sup>75</sup> and a registered homes tribunal system with its structure and jurisdiction.<sup>76</sup>

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<sup>69</sup> (1984, c.23).

<sup>70</sup> Repealed by the Blair Labour government's Care Standards Act 2000 (2000, c.14) which replaced the 1984 Act standards with more stringent levels of regulation again (38 standards were enumerated) overseen by the new Commission for Social Care Inspection.

<sup>71</sup> Implementing in this respect Law Commission Report LC 128 (December 1983)- specifically reporting to Parliament on the Registered Homes Bill 1983(Cmnd.9115).

<sup>72</sup> (1983, c.41).

<sup>73</sup> (1975, c.37).

<sup>74</sup> *Ibid.* Part One, ss1-14, with appeals under s.15.

<sup>75</sup> *Ibid.* Part Two, ss21-33, with appeals under s.34.

<sup>76</sup> *Ibid.* S.39.

The National Health Service and Community Care Act 1990,<sup>77</sup> sought to address issues of curtailment of supplementary benefit payments for new care home residents from the Department of Health and Social Security, reduction of government funding to local authorities in conjunction with recognition of the need to stimulate private care home growth already taking place.

Following the Royal Commission on Old Age and Long Term Care<sup>78</sup> in 1999, was the Care Standards Act 2000<sup>79</sup> establishing the National Care Standards Commission (NCSC), as the Government's response to the Royal Commission's recommendation for a permanent commission overseeing elderly care, followed by the Commission for Healthcare Audit and Inspection (CHAI) (also called the Healthcare Commission) by the Health and Social Care (Community Health and Standards) Act 2003.<sup>80</sup>

The development of the Care Quality Commission provides a useful case study of practical experience assisting with regulatory development. Julia Black has highlighted a number of common issues that arise with regulatory structures. "There are often tensions between independence, political control and political accountability creating an ambiguity in the responsibilities between the core executive and regulatory agencies, which both, particularly the executive, can exploit"<sup>81</sup>.

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<sup>77</sup>(1990, c.19). (sponsored by Kenneth Clarke – *Ibid.*).

<sup>78</sup> With respect to Old Age: Long Term Care – Rights and Responsibilities (1 March 1999) A Report by the Royal Commission on Long Term Care (Cm 4192-1).

<sup>79</sup> 2000, c.14

<sup>80</sup> 2003, c.43 which abolished the CHI and NCSC by Section 44, with the replacement CHAI becoming fully operational on 1 April 2004. The Secretary of State was responsible for setting overall standards for the provision of healthcare, and the new Commission was responsible, inter alia, for monitoring performance against them. Significantly Section 1 of this Act created NHS Foundation Trusts, the new semi-autonomous (i.e. in respect of Department of Health control) 'flagship' hospital mode, and Section 2 created its (largely accepted as 'economic') regulator Monitor which latter body has become the subject of much recent focus and debate in respect of its regulatory role.

<sup>81</sup> *Tensions in the Regulatory State* (Public Law 58-73)(2007)- Julia Black.

Parliamentary oversight can prove to be limited. Very often, Parliamentary Select Committees have little practical utility to impose direct legal consequences but can inflict reputational damage on ministers and regulators and they have criticised government for “blurring the boundaries” between them.

Regulation is a continuous process of negotiation, compromise and challenge on both sides of the regulator-regulatee relationship. The balance between independence and accountability is being continually negotiated between accountees and accountors. If regulatory functions are simply swallowed up into large departmental behemoths, there is no clear organisational structure for their performance.

Serious questions have arisen over the treatment of elderly care patients. Much of the research undertaken for the thesis demonstrates that the existing regulators are not successfully measuring “care” in the delivery structure. Care regulatory roles and templates being difficult to construct and modify, recent years demonstrate continuing catalogues of regulatory failure which governments attempt to react to by having enquiries and reports and changing legislation, but incremental improvement does emerge such as with the Care Quality Commission (CQC).<sup>82</sup>

Finally it is clear that there is no advocacy system in England for elderly persons<sup>83</sup> unable to represent their interests, except at an occasional individual

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<sup>82</sup> An example of putting such increments into place is the coming into force on 27 November 2014 in respect of NHS care providers, and proposals to extend the same to all other providers including private care homes on 1 April 2015, of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (2014 No.2936) imposing a complex statutory duty of ‘candour’ on care providers in Regulation 20 of those provisions where they make mistakes affecting patients thus implementing Recommendation 181 of the Francis Enquiry Report –ibid. This is referred to in published implementation guidance by the Care Quality Commission (CQC) – (November 2014) which also deals with the concurrent coming into force of “fit and proper person” complex criteria for those running such care delivery organisations – [www.cqc.org.uk](http://www.cqc.org.uk)

<sup>83</sup> Unlike in Wales since 2008 where the Commissioner for Older People (Wales) Act 2006 (2006, c.30) appointing such a person with wide ranging legal powers was politically driven into place by specific Welsh Assembly policy to do so. Arguably lower profile ones for England exist such as The Relatives and Residents Association’ (a registered charity whose remit is described as to “speak up and speak out on behalf of older

lasting power of attorney level. This draws interesting potential comparison with *guardian ad litem* systems for children in ours and in many jurisdictions.

The success of the Wales Older Peoples Commissioner has drawn praise from at least one independent body.<sup>84</sup> The lack of mental capacity component for Court of Protection support under the Mental Health Act 1983<sup>85</sup> with deputyship procedures supplemented by an enlarged Public Guardian Office role, notably in processing Lasting Powers of Attorney - largely but not exclusively for elderly people,<sup>86</sup> and an advocacy scheme, all involve a redefined lack of mental capacity component. Since the Children Act 1989,<sup>87</sup> children have had comprehensive general statutory protection similar to mentally incapacitated adults.<sup>88</sup>

There is an overarching need for adequate forms of accountability. The number of legal challenges in this area is limited where there is some use of discretionary judicial review power in general, as a component part of public law provision of accountability and checks and balances on local authority and has public body administrative action,<sup>89</sup> and the use of the Human Rights Act 1998 in

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people in care homes. It is the only national charity for older people providing a daily helpline which concentrates entirely on residential care for this age group” who gave evidence to the Commons Health Committee (with some obvious positive effect) in the Seventh Report of Session 2012/13 for the “2012 accountability hearing with the Care Quality Commission” (HC 592 – 9 January 2013) – (below).

<sup>84</sup> Robert Taylor, Chief Executive of the Age Cymru division of Age UK (4 April 2012) – “Her success in the post has helped to pave the way for...an Older Peoples Commissioner in Northern Ireland and it fuelled the debate...in Scotland”. [www.ageuk.org.uk/cymru/latest-news/archive.-](http://www.ageuk.org.uk/cymru/latest-news/archive.-)

<sup>85</sup> 1983, c.20 as modified by the Mental Capacity Act 2005, c.9.

<sup>86</sup> In the thesis author’s 35 years practising solicitor’s experience, these powers of attorney have been an enormous aid to the ongoing smooth functioning of the elderly person’s banking and other personal daily business as well as to selling their house and making care and welfare decisions.

<sup>87</sup> (1989, c.41.)

<sup>88</sup> The Care Act 2014 (passed on 14 May 2014 but progressively coming into force by secondary legislation) provides for “Independent advocacy support” in Section 67 which refers to assessments in this context, and in Section 68 which, in the same context, provides for “Safeguarding enquiries and reviews”. It clearly remains to be seen just how effective or otherwise these provisions become.

<sup>89</sup> Not least of which has been the judicial development of the doctrine of substantive legitimate expectation in a healthcare case – *R. v. North and East Devon Health Authority, Ex. p. Coughlan* [1999] EWCA Civ. 1871 which applies by analogy to elderly persons. The judiciary continuously emphasise the purely discretionary nature of any intervention by the court.

particular.<sup>90</sup> Also there is the Parliamentary and Health Services Ombudsman. However, in the overall context of elderly persons rights enforcement, the overwhelming volume of litigation is the growing area of negligence litigation by elderly patients for shortcomings in the quality of care.

## 1.5 Research methodology and sources used in writing the thesis

The research methodology used writing the thesis involved an analysis of the various public, private and local statutes, case law websites, and also private archives for primary earlier historical material, especially religious orders/organisations.

The historical part of the thesis draws on the Poor Law Report of 1834,<sup>91</sup> the Social Insurances and Allied Services Report of 1942,<sup>92</sup> and numerous parliamentary, departmental and official publications and Law Commission documents.<sup>93</sup> Also relevant are the national and private charities resources, widespread use of Westlaw, Bailii and other search sources, academic medical legal and social care journals; media sources such as documentaries, and The Economist, together with the Internet generally.

An important part of the thesis is taking account of the corporate and individual proprietors of elderly care residential facilities, and agency suppliers of

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<sup>90</sup> For example *R (McDonald) v. Royal Borough of Kensington and Chelsea* [2011] UKSC 33 which became *McDonald v The United Kingdom* 4241/12 [2014] ECHR 492 as a judgement of the European Court of Human Rights in May 2014. In summary it supports proportionate local authority statutory resource allocation in the face of budget cuts. Recent case law confirms that other paradigms apart from traditionally judicially observed ones, are becoming important.

<sup>91</sup> *Report made in 1834 by the Commissioners for Inquiring into the Administration and Practical Operation of the Poor Laws* – Senior, Nassau (1834) – [www.econlib.org/library](http://www.econlib.org/library)

<sup>92</sup> *Social Insurance and Allied Services* – Beveridge, W (1942) Cmd.6404.

<sup>93</sup> [www.lawcommission.justice.gov.uk](http://www.lawcommission.justice.gov.uk). Usually complied after lengthy expert and experienced persons' consultation/participation.



nursing and care personnel. In that context, the economic analysis from the Institute for Fiscal Studies<sup>94</sup> publications is important as is the King's Fund.<sup>95</sup>

At the early stages of the research it was hoped to conduct interviews with care providers both private and commercial, regulators and the various religious organisations. Despite strenuous efforts, all attempts to undertake studies and research were refused, other than the exceptions of the kindness of some local authority personnel and a number of private care delivery organisations.

Excluders included various Christian groups and societies. The lack of co-operation, driven by an historic lack of a legal duty of candidness, its association with issues such as doctor/patient and nurse/patient confidentiality, coupled with a fear of litigation, are likely to be serious issues for future research in this field.

The sources used in writing the thesis may be explained: in addressing the main regulatory issues, an historical focus is regarded as an essential background. Legal and cultural aspects of care are necessarily involved in this process, but the main focus is on elderly care homes. Surprisingly this area has not been well researched, although it is the subject of recent reports finding that care has not been well delivered to the elderly.<sup>96</sup>

Apart from Department of Health research and reports published from time to time, the main regulatory issues are addressed by Tony Prosser,<sup>97</sup> a particularly well

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<sup>94</sup> [www.ifs.org.uk](http://www.ifs.org.uk)

<sup>95</sup> [www.kingsfund.org.uk](http://www.kingsfund.org.uk).

<sup>96</sup> *Inquiry into 'harrowing' care home abuse calls for NHS style regulation* The Times (9 June 2014) – Rosemary Bennett reporting on a West Sussex care home.

<sup>97</sup> *The Regulatory Enterprise – Government, Regulation and Legitimacy* – Tony Prosser (Oxford: Oxford University Press – 2010). Professor Tony Prosser is a regulatory law academic at Bristol University.

informed and researched law academic, and Michael Hill,<sup>98</sup> who has researched the wider social issues involved to some extent.

In terms of the leading academic institutions, the Institute of Gerontology of King's College at the University of London<sup>99</sup> has active research based upon co-operation between different clinical disciplines with derivative research projects into various aspects of elderly care, including offering a PhD degree course in gerontology.

Also, the School of Health Sciences of City University London<sup>100</sup> has carried out and continues to carry out research into elderly care but specifically clinically orientated aspects of it, and Aston University, Birmingham has its Aston Research Centre for Healthy Ageing (ARCHA), which looks at strategies 'to understand and arrest age related decline.'<sup>101</sup>

In addition, various funded bodies are revisiting elderly care issues, and some aspects of a regulatory nature, with some frequency including the Joseph Rowntree Foundation,<sup>102</sup> the King's Fund,<sup>103</sup> the British Geriatrics Society,<sup>104</sup> Age UK<sup>105</sup> and the Alzheimers Society.<sup>106</sup> On the whole these examine funding or broader economic and social aspects of elderly care and analyse the same but largely on a piecemeal basis or across a more narrow spectrum of issues than the holistic approach of this thesis (with its historic backdrop) so as to contextually understand modern issues in elderly healthcare delivery.

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<sup>98</sup> *Social Policy in the Modern World* – Michael Hill (London: Blackwell Publishing 2006). Michael Hill is a social policy academic, Newcastle University.

<sup>99</sup> [www.kcl.ac.uk](http://www.kcl.ac.uk).

<sup>100</sup> [www.city.ac.uk/health/research](http://www.city.ac.uk/health/research).

<sup>101</sup> [www.aston.ac.uk/lhs/research](http://www.aston.ac.uk/lhs/research)

<sup>102</sup> [www.jrf.org.uk](http://www.jrf.org.uk).

<sup>103</sup> [www.kingsfund.org.uk](http://www.kingsfund.org.uk).

<sup>104</sup> [www.bgs.org.uk](http://www.bgs.org.uk).

<sup>105</sup> [www.ageuk.org.uk](http://www.ageuk.org.uk).

<sup>106</sup> [www.alzheimers.org.uk](http://www.alzheimers.org.uk).

The thesis utilises academic and government reports. As explained it was not prove possible to undertake fieldwork and although access was requested to archived materials none was given by any of the organisations approached.

Care of the elderly has a long tradition over many centuries through individual and institutional support. Elderly care's sudden expansion is one of the most complex and difficult challenges to face modern society. Across the world and especially amongst the more developed nations, people are living longer as the average age is rising with falling death rates and falling birth rates. The only exceptions to this are societies where premature death remains a very common occurrence, for example in the societies of Southern Africa where disease is a major contributor of low life expectancy. Even in many societies where early death is common, for example in Russia, low birth rates are contributing to the overall ageing of the society.<sup>107</sup>

Many OECD countries face similar issues to the position in England as countries struggle to provide a satisfactory basis for covering the costs of elderly care but also finding a suitable regulatory structure to ensure care quality delivery and patient safety is an ongoing debate.<sup>108</sup> European experiences of three

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<sup>107</sup> *Ageing Societies* - Michael Hill 2006 (*op cit.*).

<sup>108</sup> The Swedish, Italian and German perspectives on these issues were the subject of recent reports by academics and other experts to the COST Action Local Public Sector Reforms Conference in Potsdam (14 – 16 May 2014). The Swedish paper: *Between market and hierarchy- The case of public utility and elderly care in Sweden*- Country report (Draft version – author unclear) speaks of well-established elderly care municipal responsibilities being entitlements based on need rather than ability to pay and market orientated reform transforming the private provider side of care delivery.

The Italian paper: *Still fragmentation? Public utilities and social services in Italy after post – NPM reforms*- G. Citroni, Calabria University, A. Lippi, Florence University, and S. Profeti, Bologna University, speaks of bureaucratic issues associated with fragmented elderly care delivery arising from the multiple historic components of the modern unified Italian state, with fragmentation being only partially reduced recently after enormous effort.

The German paper – *The Provision of Local Public Services in Germany; A Long-Term Sectoral Comparison*- F. Bonker, Riesa University, J. Libbe, German Institute of Urban Affairs, and H. Wollman, Humboldt University Berlin, spoke of reasonable satisfaction by the public in elderly care delivery with changes in the 1990's by way of expansion of private providers, but a pre- World War 2 public delivery structure had benefitted much from a hybrid but strong historic role played at local level by welfare associations in personal services.

developed states, Sweden, Italy and Germany reveal remarkable parallels with the UK.

## 1.6 Organisation of the thesis

The thesis is organised in ten chapters. After the introduction in Chapter 1 identifying the current overview of contemporary issues an historical approach is followed in Chapter 2. What emerges is that elderly care is to be found bound up with care of the poor it is also linked to family members and their care of close relatives and loved ones. Chapter 2 is on the early history of care and how there are distinctive trends A rather diffuse and locally delivered system of elderly care existed. Families and neighbours also supported by Monastic institutions and alms giving.

Notable features of this period are that “the poor, aged and impotent” people were grouped together.<sup>109</sup> The need to define charitable status and also to ensure that charitable care had the necessary public benefit legal component. Local parish rate and personal resources, including those channelled via charities, remain at the heart of care provision throughout nearly the entire spectrum of the study until the nineteenth century when institutions such as the friendly society take on a role born of economic and social change. Voluntary hospitals also emerge in significant numbers to offer a future state framework, but at no point does the charitable body, or indeed other voluntary components become displaced.

The post-1537 poor law legislation has pre-1537 roots in terms of the upper classes arguably seeking to control beggars as early as 1388. There is a transition

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<sup>109</sup> For example: Statute for the Punishment of Vagabonds and the Relief of the Poor and Impotent Persons 1547 (1 Edw.6, c.3).

therefore to the post-1537 Tudor (old) poor law, and a further transition to the 1834 (new) poor law,<sup>110</sup> the latter becoming abolished entirely in 1948.<sup>111</sup>

Practical provision for old age in a number of respects seems to largely follow its own path until the twentieth century. Manorial court rolls as early as 1352 show evidence of ageing land tenants, and occasionally freeholders, entering into legal arrangements with younger persons to provide rent, produce and even clothing for their old age. Royal Navy officers in the 1600's appear to become recipients of the first actual pension scheme as we would understand such.

Chapter 3 is on Elderly Care in the 19<sup>th</sup> century to the development of the National Health Service and covers the period running from the Victorian era through to the development of the National Health Service including the Beveridge Report. It was not until 1908 that general statutory provision is made for pensions nationally.<sup>112</sup> Then in 1911<sup>113</sup> and 1929<sup>114</sup> is further statutory progression, particularly in respect of elderly care. Chapter 3 shows how the influence of Bentham, Chadwick and social reformers drove events, and how this shaped the role of the state in delivering care for the poor and the sick. Following the end of the 19<sup>th</sup> century, social and economic change of 'tidal' proportions came in the wake of World War 1, which had obliterated the landed classes and gave way to mass unemployment and economic slump, so social structures were emerging in this inter-war interval to fill a void.

The foundation of the welfare state after the Second World War came at a time when social and economic need was at its most acute. Chapter 4 traces the influence of Beveridge (1897-1963), who was aware at the time of World War 2 of

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<sup>110</sup> The Poor Law Amendment Act 1834 (4 & 5 Wm.4, c.76).

<sup>111</sup> By the advent of the welfare state generally, and specifically the National Assistance Act 1948 (11 & 12 Geo.6, c.29).

<sup>112</sup> Old Age Pensions Act 1908 (8 Edw. 7, c.4).

<sup>113</sup> National Insurance Act 1911 (1 & 2 Geo.5, c.55).

<sup>114</sup> Local Government Act 1929 (18 & 20 Geo.5, c.17).

the social devastation which unemployment after World War 1 had produced. His biographer<sup>115</sup> ably demonstrates his social engineering skills, reflecting Chadwick in the 19<sup>th</sup> century. It is also possible to identify an umbrella structure that emerged with the Victorian voluntary hospital and the Victorian workhouse. Also the wartime Coalition Government<sup>116</sup> continued implementation of national emergency hospital provision as building blocks toward the NHS. Beveridge drew his inspiration from these early foundations.

The Social Insurance and Allied Services Report of Sir William Beveridge (1942)<sup>117</sup> became statutory reality in July 1948. The Labour Government of this period also engaged in nationalisation of most of the important utilities and the major coal, steel and railway industries. This placed central government at the centre of the relationship between the citizen and the state.

The creation of the NHS in 1948 is an important moment in health care provision. The start of state intervention in a national health service brings community values into social care delivery, but elderly care retained its hybrid nature. It is also an important period for the growth in local authority led elderly care services. As we will see local government was given important responsibilities for the elderly notwithstanding the creation of a nationalised health service. These included residential and domiciliary care. This made local government a pivotal part of elderly care through home care provision or also enabling local authorities to establish and run care homes. This was a defining period for elderly care and by 1968 local government was given a general power to promote the welfare of the elderly.

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<sup>115</sup> Jose Harris- *William Beveridge - A Biography* (Oxford: Clarendon Press 1977).

<sup>116</sup> Actually formed by Winston Churchill on 13 May 1940 –( [bbc.co.uk/history/worldwars](http://bbc.co.uk/history/worldwars)) but the legislation was the Emergency Powers (Defence) Act 1939 (2 & 3 Geo.6, c.62) passed on 24 August 1939.

<sup>117</sup> *Social Insurance and Allied Services*-(November 1942) - HM Stationery Office (Cmd.6404).

A large proportion of elderly lived in their own homes supported by their families but also supported through home care systems. Local authority delivery of elderly care services reached a peak in the 1980s. It was set to change with the private sector market developing a market in private care homes.

Chapter 5 sets out the arrangements for elderly care in Britain through the aftermath to Beveridge implementation. This covers the period from the development of the NHS from the 1950's onwards witnessing significant political change and economic austerity.

The 1980s is seen as a period that transcends a political reversal by a Conservative Government of much of the post-war nationalised industry structure (utilities, telecommunications, railways, coal, steel, etc.) based upon a political philosophy that private ownership, accompanied by suitable economic regulatory competitive stimulus, achieves more efficiency<sup>118</sup>. The change in public provision of social assistance in 1980 gave rise to private homes entitled to central government subsidy for looking after the elderly. This was an indirect result of privatisation policies and their introduction in other public sector areas.

Chapter 6 addresses the question of how to regulate elderly care in the context of the development of the Care Quality Commission (CQC), and how the Commission gained its current role and functions are considered in some detail.<sup>119</sup> The role and inspection functions of the Care Quality Commission are very much work in progress and are likely to be refined and developed over the coming years. The Care Quality Commission is very much an example of a regulator that has been transformed by the tragic consequences of the poor care demonstrated in 2001 by

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<sup>118</sup> And enormous sale proceeds going into H.M.Treasury.

<sup>119</sup> House of Lords Select Committee on Public Service and Demographic Change Report – *Ready for Ageing?* (14 March 2013) – HL Paper 140.

the Kennedy Report into care shortcomings at Bristol Royal Infirmary, and in the Francis Report. Sir Ian Kennedy plays a particularly significant pivotal role and driving force into the contemporary regulatory process.

Then, Chapter 7 sets out the challenges facing the early days of the CQC and how the findings of the Francis Report into failing at Stafford hospital has re-shaped and focused its role and functions. The functioning of the main healthcare regulator, the CQC, is looked at in detail together with the impact of the Robert Francis Report of 2013.

It is argued that whatever regulation is invoked, care has to be at the centre of considerations where elderly care is concerned. It fits very well the analysis offered by Julia Black as a case study of how to learn from regulatory mistakes and how in the end this may lead to real improvements. It is too soon to say whether this will happen but it is certainly the case that the Care Quality Commission has taken very seriously many of the problems of health care in general and elderly care in particular.

This is followed in Chapter 8 by an analysis of how elderly care is held accountable in the UK and the various ways elderly care is being made more transparent. The Chapter examines the European Convention human rights issues in an overall accountability context and specifically how the Human Rights Act 1998<sup>120</sup> is functioning or not in an elderly care context. There is also consideration of 'legitimate expectation' in case law and the proportionality concept<sup>121</sup> that arises in some of the leading cases such as *YL v. Birmingham City Council* in 2007<sup>122</sup> and

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<sup>120</sup> 1998, c.42. Coming into force in October 2000.

<sup>121</sup> *R v North and East Devon Health Authority, ex p Coughlan* [1999] EWCA Civ.1871 *Ibid.* (though the applicant was severely disabled but not elderly, the principles for elderly care situations arise by analogy/ implication).

<sup>122</sup> [2007] UKHL 27.



*McDonald v. The United Kingdom* in 2014.<sup>123</sup> As will be explained human rights issues in elderly care delivery have given patients some additional protection under the law. This is limited because the courts generally avoid policy matters allocated by statute for non-judicial decision making.

One of the seriously outstanding human rights issues however is in the area of abuse of the elderly in care homes where a perception prevails that human rights engagement has ‘hardly scratched the surface’ of the overall problem.

In Chapter 9, some case studies are examined setting out current impressions about how elderly care is being delivered. The case studies are widely drawn and cross the variety of ways that health care for the elderly is delivered together with some personal interviews giving a personal perspective from some of the main providers of elderly care. Care homes proved impossible to access in terms of permission to undertake research or interviews. Cavendish however in particular provides an invaluable insight of ‘ground-level’ care delivery issues in terms of shortcomings and successes, and in addition throws light at the practical delivery level upon the sheer cost of lack of ‘joined-up’ care delivery to the elderly and others.

Finally, Chapter 10 of the thesis brings together the main conclusions. Prosser’s very significant contribution to the overall debate has characterised elderly care regulation as one that is part of a joint enterprise in regulation that crosses many disciplines and is co-joined to the role of the Secretary of State.<sup>124</sup> Regulation is also linked to various elements of co-regulation such as social rights, welfare and what Prosser calls a “social solidarity approach.” This provides enormous regulatory challenges that post-Francis require consideration of the culture of care and the

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<sup>123</sup> [2014] ECHR 492.

<sup>124</sup> *The Regulatory Enterprise: Government, Regulation and Legitimacy*- Tony Prosser (2010) Oxford: Oxford University Press – page 135 where he concludes the Chapter – *The Care Quality Commission*.

identification with the elderly rather than the service providers. It is also an example of learning from mistakes and building regulation from the lessons of many regulatory failures.

The continuing expansion of chronic care and dementia numbers amongst the elderly in particular are very challenging future resource issues coupled with the increased complexities of the demands on the skills of those engaged in elderly care delivery, including invasive procedures which used to be carried out by nurses. Cavendish identifies these issues with a workforce largely challenged by high turnover of workers due to poor pay and conditions, and who need new training structures and associated financial investment to model themselves on the well run bodies Cavendish saw. She also identified the heart of the concept of 'care' in its delivery.

Abuse of the elderly in care homes remains far too rife and scandalous, and is hardly properly engaged by the regulatory systems we have, so that there is now quite recent officially sanctioned resort to hidden cameras.

One of the principal conclusions of the House of Lords Report of 14 March 2013 of its Select Committee on Public Service and Demographic Change<sup>125</sup> is that too many changes, and party political changes in government, make policy making in this area difficult and engaging. There are also lessons for the regulation of elderly care in particular with the experience of the Care Quality Commission (CQC). This is a fast and challenging area where the future of regulation is likely to be dominated by responses to the recent Francis Report, which is partially addressed by the Government currently.<sup>126</sup>

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<sup>125</sup> HL Paper 140.

<sup>126</sup> In the Care Act 2014 (2014, c.23) on which a Government statement declared that "the Act delivers key elements of the government's response to the Francis inquiry ... increasing transparency and openness and

At the time of writing change is still in vogue. Part 1 of the Care Act 2014, progressively coming into place, follows the main recommendations of the Law Commission 2011 Report. The new Act provides a framework that places the needs of the elderly at the forefront of care. There are nine complex criteria<sup>127</sup> that cover “well-being.”

These reforms are overdue and follow the findings of the Francis Report. However, where that Act provides for the CQC to take responsibility for “market oversight” of failing care homes, and others,<sup>128</sup> for which its current people possess no skills whatsoever, it is a remarkable government proposal the effects of which remain to be seen. Effective expertise of this type is expensive to contract in, driving costs upwards.

The February 2015 supplemental report by Francis to the Government on NHS whistleblowing progress reflected to a surprising extent the lack of progress on changing cultures towards transparency in healthcare delivery, and has triggered urgent remedial action by Government.<sup>129</sup>

It is clear that elderly care is likely to remain a highly complex subject that crosses a wide spectrum of opinions and political perspectives.

Despite much polemical debate, beneath the surface there are really good examples of elderly care and it remains for the foreseeable future delivered in many cases by friends and relatives of the elderly patient. It remains to be seen whether this will remain possible in an ageing population. One final observation is that in

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helping drive up the quality of care across the system.” – *Care Bill becomes Care Act 2014* - Norman Lamb, Care and Support Minister (15 May 2014) [www.gov.uk/government/speeches/care-bill-becomes-care-act-2014](http://www.gov.uk/government/speeches/care-bill-becomes-care-act-2014).

<sup>127</sup> Listed in Section 1 (2) (a) to (i) of the Care Act 2014- *ibid*.

<sup>128</sup> Sections 53 to 55, Care Act 2014- *ibid*.

<sup>129</sup> *NHS whistleblowing procedures in England*- (23 February 2015) House of Commons Library – Standard Note : SN06490.

Wales there is recently appointed elderly care Commissioner and this may be something to consider eventually for the rest of the UK- although it is too soon to say whether this is likely to be effective. Nevertheless the possibilities of developing this template into a 'champion' for the elderly in England are briefly explored as a possible further increment in these very permanent issues.

## CHAPTER 2: An introduction to the history of elderly care

### 2.0 Introduction

In this chapter, and in Chapter 3, we consider the main features of the history of elderly care in Britain. It includes a wide range of social, economic, political and moral/religious influences. In the case of elderly care, it is broadly about how differing influences, including charitable and ecclesiastical law came to leave their mark on the way the elderly became treated in society. The ecclesiastical legal jurisdiction developed from Christian sources and the eventual recognition of an established Church of England that was interlocked to a state jurisdiction including charitable laws are important. There was a strong sense of decentralisation as local care delivery took place in the lay parish as a local authority. The slow development of a state hospital system and poor law workhouse structures are also relevant from medieval times. This chapter follows a chronological order taking into consideration the medieval foundations of elderly care and concluding with the new Poor Law early in the 19<sup>th</sup> century, the Victorian hospital system as the embryo of the modern system of elderly care as part of a health care delivery system. The 19<sup>th</sup> century is examined in some detail in Chapter 3.

The Ancient European philosophical influences on contemporary care are discussed.<sup>130</sup> In addition, influences imported into European ethical values, such as links to Confucianism and Buddhism, are considered amongst other religious and historical schools of thought.

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<sup>130</sup> Professor Roger Crisp, Oxford University, includes stoic ethics from Athens as one of the then four main ancient Greek schools of philosophical thinking, alongside that of Plato, in his *Homeric Ethics* Chapter 1 contribution of his editorship of *The Oxford Handbook of the History of Ethics*.

Care is at the heart of many religious precepts and beliefs, as well as being central to human values and relationships. Care of the elderly is present in Judeo/Christian beliefs and also is evident in many faiths and amongst many cultures in the world. The Anglo-medieval inheritance of care and support for the elderly owes much to Rome and the influence of Roman Catholic theology but is not the sole preserve of Christianity.<sup>131</sup> However, in institutional terms, the establishment and growth of the monastery have proved to be of great significance up to and after the Norman Conquest of 1066.

The Monastery was the centre of religious and spiritual life in Britain. Monasteries with varying degrees of application also addressed poverty, education and elderly care. They all shared many common features, hand in hand with the development of charitable law with its own increasing sophistication to avoid abuse. Monastic institutions such as the Benedictine Order provided personal care or alms to individuals in need.<sup>132</sup> Their resources originated from private and royal gifts. William I, when starting off the Norman dynasty after the Battle of Hastings in 1066, rewarded those who had supported him with grants of lands and titles, as well as giving lands to the Church in thanksgiving for winning the Crown.<sup>133</sup>

Centralised Royal power and local government at parish level accepted and shared responsibilities with care delivery primarily a mixture of private alms giving as well as limited public provision.<sup>134</sup> In 1066, the average life expectancy was no more

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<sup>131</sup> For example, the Franciscan Order, who first arrived in England in 1224, have stated on their website that “The friars served the poor and the outcasts”. – [www.friar.org/about-us/our-heritage](http://www.friar.org/about-us/our-heritage). And see also similar evidence in respect of the Benedictine Order at [www.osb/gen/benedictines](http://www.osb/gen/benedictines).

<sup>132</sup> [www.osb/gen/benedictines](http://www.osb/gen/benedictines).

<sup>133</sup> [www.royal.gov.uk/TheNormans](http://www.royal.gov.uk/TheNormans).

<sup>134</sup> The Statute of Cambridge 1388 (12 Ric.2, c.7) provided that each county hundred (that is the subdivision of the county) became responsible for the “impotent poor” and those who “because of age or infirmity” were incapable of work – ([www.witheridge-historical-archive.com/poor](http://www.witheridge-historical-archive.com/poor)). There is remarkable continuity of this local government responsibility via parishes in the Statute for the Provision and Relief of the Poor 1552 (5 & 6 Edw.6, 2) (one of many such statutes) up to and including the Local Government Act 1929 (19 & 20 Geo.5,

than 33 years<sup>135</sup>, and by the Elizabethan period, the average life expectancy was 38 years although 30 per cent of children died before the age of ten; even Catherine of Aragon lost five of her six children in infancy. This represents a small, but nonetheless tangible increase.

A growth in benevolence can be traced as one of the causes of this marked increase in life expectancy. It was often undertaken by private individuals for public benefit in a given locality for many centuries. The adoption of a lifetime trust or the will trust was commonly used.<sup>136</sup> The motives for such developments were mixed: partly undertaken for the public good and partly as an act of redemption. This beginning of benevolence mixed with altruism persists today. The stresses and strains of publicly funded care are clear.

For many centuries, statutes categorised the elderly in need in the same class of persons as the poor and “impotent in need.”<sup>137</sup> Recognisable, however, is that care was given to those that were less worthy – a kind of divine retribution for wrongdoing or as part of a moral perception about good and evil.<sup>138</sup>

During the pre-reformation the period of absolute monarchy under Divine Right, assisted the development of a common strategy that was supported by the State.<sup>139</sup> This gave rise to a complex design of delivery from the Church and its bishops and secular clergy and diocesan structures, with monastic and other non-

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c.17), Section 1 of which provided for the poor law transfer of functions in relation to the then established statutory local authorities. Central government itself didn't deliver any care until the National Health Service Act 1946 (1946, c.81) came into effect on 5 July 1948.

<sup>135</sup> [www.history.stackexchange.com/.../what-was-the-life-expectancy-in-medieval](http://www.history.stackexchange.com/.../what-was-the-life-expectancy-in-medieval).

<sup>136</sup> Bishop Walter Suffield of Norwich (1257) – below (a good example of private will trust provision).

<sup>137</sup> A further example being the Statute for the Punishment of Vagabonds and Relief of the Poor and Impotent Persons 1547 (1 Edw.6, c.3).

<sup>138</sup> Ancient Biblical sources for this include the perceived punishment for Isaac's blindness and childlessness (Re Genesis 20:16 and Genesis 27:1) and the story of the Sodomites being afflicted with blindness exemplifying the connection postulated between disability and divine punishment by blindness (Genesis 19:11).

<sup>139</sup> A perception not completely displaced until the Bill of Rights 1689 (enacted 16 December 1689) (1 Will & Mary, c.2).

diocesan controlled orders with their regular clergy. The incorporation of the status of religious bodies was similar to other Royal foundations, common to medieval charters for cities and towns. Their incorporation through the status of the grant of a Royal Charter to create trading companies (as early as the 13<sup>th</sup> Century),<sup>140</sup> this also extended to partnerships of individuals, trusts, incorporated bodies which also became established through various private Acts of Parliament and friendly societies.<sup>141</sup>

Many of these different legal forms ranging from corporate to contractual are today directly or indirectly involved in some elements of care delivery to the elderly. As will be seen, the growth of private sector care delivery is accompanied by an expansion in the number of private limited companies for that purpose.<sup>142</sup> It is clear that elderly care comprises many elements – voluntary, family charitable as well as private and religious.

## 2.1 Medieval elderly care: religious values and beliefs

Elderly care is, at times, deeply attitudinal and is also related to religious influences, as well as the influence of philosophical or moral values. There is also a degree of symmetry between care delivery and the poor law. The importance of family delivery of elderly care, is seen as supportive of family values and reinforced by religious and moral principles. There is a strong tradition in England of family care

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<sup>140</sup> The Wellington Market Company (1244) – [www.wellingtonmarkets.co.uk](http://www.wellingtonmarkets.co.uk).

<sup>141</sup> The Friendly Societies Act of 1793 (33, Geo. III., c. 54) attempted to licence (through registration and regulation) friendly societies.

<sup>142</sup> As mentioned in the introductory chapter, it is a matter of some regret that requested access to the archives of these monastic institutions was almost universally declined. The climate of secrecy appears to shield institutions from academic research and scrutiny. The plethora of law suits and legal challenges makes many religious orders highly sensitive to any archival research. It is likely that future research agendas should consider the importance of empirically led research into the workings and operation of care homes.



for the elderly and this may come from the early history under moral and religious influences.

Studies of the post Norman-conquest in nine counties of England have shown that hospitals and alms-houses were routinely built and run to provide shelter for the elderly, the sick, and travellers.<sup>143</sup> Indeed the Latin *hospes* (meaning guest, stranger or foreigner) gave rise in years to come to the hospital as an institution. Such institutions rarely offered a cure but and frequently provided shelter.<sup>144</sup> There are numerous hospital records that support this observation. In Canterbury, Kent, for example, St. John's Hospital was reputedly founded by Archbishop Lanfranc<sup>145</sup> in 1084 "for the lame, weak and infirm."<sup>146</sup> It is known that in Harbledown in that county St. Nicholas' Hospital also existed in 1084.<sup>147</sup> There was also a row of alms-houses and, between that period and the end of the 16<sup>th</sup> Century, there were at least another 18 such places in the same county. These examples show the wide divergence of the places where care was delivered and is a legacy of that almost forgotten past.

Lanfranc (1005 - 1089) a secular clergyman provided an account of this period. He was in charge of an archdiocese and its secular clergy and this was typical of many dioceses across the country that had charitable commitments running alongside spiritual and pastoral activities engaging with the laity who were committed to their guidance. Regular clergymen, on the other hand, belonged to monastic or other orders with lifestyle differences (having taken the vow of poverty),

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<sup>143</sup> At [www.english-heritage.org.uk](http://www.english-heritage.org.uk) and [www.almshouses.org.uk](http://www.almshouses.org.uk) the last of these still being a registered charity (No. 245668) which supports 1700 independent alms-house charities throughout the UK stated at its website to be providing homes for 35000 people, primarily the elderly or their former carers without sufficient means of their own, and supported by bequests from will trusts by the wealthy over the centuries or a mainstream charity.

<sup>144</sup> *The Role of the Hospital in Medieval England: Gift-Giving and the Spiritual Economy* – Sheila Sweetinburgh Dublin, Four Courts – (2004).

<sup>145</sup> (C. 1005-1089).

<sup>146</sup> [www.machadoink.com](http://www.machadoink.com).

<sup>147</sup> *Ibid.*

operating from monastic institutions, including the hospitals. McCleery's study of care for the elderly notes how the religious aspects of care dominated. Elderly care institutes were "usually they were run by monks or nuns and would offer some general nursing skills."<sup>148</sup>

Medieval England also provided a link for monasteries and health care to be combined with McCleery writing that "monasteries frequently incorporated hospitals into their grounds. The poor, sick and elderly would be given clean clothing, comfortable bedding and good food, as well as spiritual comfort."<sup>149</sup> By the time of the Norman conquest in 1066, the Anglo-Saxon's had "36 houses in England of the Benedictine order and by the time Henry VIII had closed them all (from 1537 onwards) there were 136."<sup>150</sup> The biggest communities were abbeys run by an abbot, and the smaller were priories run by a prior. In Somerset, Glastonbury Abbey was one of the oldest and most important in the country. Romsey Abbey was a convent of Benedictine nuns. The nuns looked after people who were too old or ill.<sup>151</sup> Analysis reveals a multiplicity and their origins.

There are many religious organisations that have medieval origins but still continue to provide care for the elderly in present times. The Benedictines are a case in point; and there is also the Cistercians (a derivative order of the Benedictines originating in France in 1098),<sup>152</sup> the Carthusians (whose English foundation arises in about 1127),<sup>153</sup> the Dominicans (in England from about 1221),<sup>154</sup> the Franciscans

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<sup>148</sup>Iona McCleery (Durham University unpublished paper – 10 July 2007) – [www.dur.ac.uk/CentrefortheHistoryofMedicineandDisease](http://www.dur.ac.uk/CentrefortheHistoryofMedicineandDisease).

<sup>149</sup>*Ibid.*

<sup>150</sup>*Ibid.*

<sup>151</sup>[www.request.org.uk](http://www.request.org.uk).

<sup>152</sup>[www.osb.org/cist/](http://www.osb.org/cist/).

<sup>153</sup>[www.chartreux.org](http://www.chartreux.org).

<sup>154</sup>[www.op.org](http://www.op.org).

(coming to England from Europe in about 1224),<sup>155</sup> the Augustinians (forming in England in two stages in 1244 and 1256).<sup>156</sup> The Poor Clares nuns following St. Claire tradition<sup>157</sup> also are apparently significant.

The expansion of the numbers of religious orders often overlapped with their care obligations. Although there were distinct mission statements as part of the link to the relevant founding saint, they shared remarkably similar goals and objectives. The European spread of Christianity was accompanied by care values. Shahar<sup>158</sup> observes that various forms of modest pension provision in some monastic communities for clergy and employees in the 1200-1400 period became influential

Many of the manorial settlements allowed “some of the lords obtained or bought a pension for their retainers or their widows in one of the monasteries. Some provided for their accommodation in one of the alms-houses.”<sup>159</sup>

In 1378 St. Mary’s Hospital in Staindrop, Durham, was founded for a number of poor elderly men, “probably retainers and servants of the hospital’s founder.”<sup>160</sup> Elsewhere Shahar<sup>161</sup> describes 14<sup>th</sup> Century evidence of landless peasants becoming paupers when old age deprived them of physical ability to work for a living, and an established rule of common law or, in places, local law of the right of these paupers to “glean” the harvest leftovers after each harvest.

Gratian in the *Decretum* set out the Canon law authorities for charity and poor relief around 1140 based upon moral, Christian and charitable principles but is understood to have drawn upon legal sources of several centuries earlier.

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<sup>155</sup> [www.franciscans.org](http://www.franciscans.org).

<sup>156</sup> [www.augustinians.org](http://www.augustinians.org).

<sup>157</sup> [www.poorclare.org](http://www.poorclare.org).

<sup>158</sup> S. Shahar, *Growing Old in the Middle Ages* (London: Routledge, 2004) – where much further factual material can be found with empirical data.

<sup>159</sup> *Ibid*, p.155.

<sup>160</sup> *Ibid*, p.123.

<sup>161</sup> *Ibid*, p.153.

Canon law, taught through the medium of the then dominant Roman Catholic faith, apparently was a prime influencing motivator for bringing into being these institutions for both the providers and the users. The latter were expected to pray for the souls of others, especially wealthier people who donated money, food or other resources to the hospital or monastery. The former dispensed charity as a bounden duty, including giving alms to the poor, often from a special almonry by the monastery gate. The donors had the comfort of knowing that their own Heavenly destination after death was well provided for,<sup>162</sup> but possibly just pure self-interest?

If all secular authority in the land derived from the sovereign, who at the time was perceived to rule 'by Divine right',<sup>163</sup> an appearance of outward Christian piety anyway would be seen to be doing the 'right' thing which Shahar portrays. Other sources appear to throw more light on the larger picture in terms of the predominant ecclesiastical influence on everyday life (not least church legal jurisdiction).

The Papal decretal of Pope Gregory 1X (1227 – 1241) is an illustration of the expanding power of the church. It urged:

*"the faithful to seek their salvation by bequeathing part of their wealth to pious causes...the impious testator, who refused to observe this exhortation might be denied the Eucharist and interred in unconsecrated ground. A similar fate might befall the person who died intestate, for he too had failed to make provision for works of great mercy before death, but to ensure his salvation the Church obtained the right to administer his estate and to distribute a portion of it ad pias causas."*<sup>164</sup>

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<sup>162</sup> *Ibid*, p.165.

<sup>163</sup> Arguably a lingering historic perception until displaced by statute in the form of the Bill of Rights 1689.

<sup>164</sup> *Ibid*, p.107.

*“Bequests to pious causes (a wide range of objectives were embraced by this term including the upkeep of religious houses and gifts for the relief of distress and suffering) were particularly favoured by the ecclesiastical courts, which by the reign of Henry III (1216 – 1272) had secured an exclusive jurisdiction over the testament of personality.”*<sup>165</sup>

The bishop or Ordinary<sup>166</sup> of every diocese therefore frequently had a hand in administration of these testamentary gifts.<sup>167</sup>

One of the fixed principles of classical canon law traversing back into Anglo-Saxon times in England was the cultural sentiment that there should be areas of life left to the judgement of the Church, and in this connection monastic activity was also very visible in pre-1066 England, primarily then the Benedictine order.<sup>168</sup>

In terms of private benevolence, Shahar makes the point that “the aged as such were not counted among those whom the Scriptures defined as deserving of assistance” and goes on to note that the target categories were widows, the orphaned, the sick and the disabled. She further observes that

*“only during the pontificate of Innocent IV (1244 – 1254) did Canon Law begin to distinguish between those...who had means and those who had none, with a view to legal assistance. Pope Innocent IV ruled that poor widows, orphans, cripples, lepers, prisoners and poor old people could bring their cases directly to the ecclesiastical court. Those who had means.....would be allowed to*

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<sup>165</sup> *Ibid*, p.130.

<sup>166</sup> A term still used in canon law today. *The Code of Canon Law* (London: Collins 1983) – updated at [www.intratext.com](http://www.intratext.com).

<sup>167</sup> Gareth Jones, *History of the Law of Charity 1532-1827* (Cambridge: Cambridge University Press, 1969).

<sup>168</sup> [www.osb.org](http://www.osb.org).

*appeal to the ecclesiastical court. ..This papal legislation..... reveals...that not all the aged were supported by their offspring...*<sup>169</sup>

Hence possibly one of the earliest forms of what might today be called legal aid appears to have been introduced by remedial legislation, available throughout Christendom, to achieve access to the courts' justice rather than directing Christianity to categorise the elderly as a target for their almsgiving.

## 2.2 Early Jurisdictional Development

Care of the elderly was relevant to the way in which charity law as well as ecclesiastical law developed. Charity law began as follows. Post Norman-conquest an entrenched common law system evolved. This included private law relationships between private citizens. Historical records show that church law was influential on the daily lives of ordinary people.<sup>170</sup>

The elderly with sufficient assets attempted to utilise charitable or other gifts for fiscal planning purposes. The government of the day were fully aware that such devices were depleting what they expected to receive from elderly people's estates. This gave rise to much legislation attempting to restore taxation to the State, a facet of charity legislation, including the good regulation of charities, which continues today.<sup>171</sup> Charitable taxation has become much fought over including the obligation to undertake Chancery repairs.<sup>172</sup>

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<sup>169</sup> Shahr *ibid* p.165.

<sup>170</sup> Common Law jurisdiction in medieval times was much narrower (see below) than it later became when it developed the concept of the stare decisis doctrine of binding precedent, and often any required statutory intervention would recite in the preamble to that statute the common law rules which it was seeking to change.

<sup>171</sup> For example, the Charities Act 2011 (2011 c.25).

<sup>172</sup> Itself a complex land law/charity law levy. Church funding structure highlighted in the House of Lords judgement in 'PCC of Aston Cantlow v. Wallbank [2003] UKHL 37' in which Lord Scott in particular (at paras.

The jurisdiction of the Ecclesiastical court continued to overshadow people's lives, including the elderly, on issues of marriage and its validity, gifts, and the whole area of the law of succession and its implications for passing property from generation to generation.

Care of the elderly was mentioned frequently in medieval law and the influence of the various ecclesiastical law sources sustained the development of the law of charity. The main jurisdiction fell to the Chancellor including early medieval development of the charity law *cy-pres* doctrine which by-passed the rigidities of the then common law system via the use of the legal presumption that a charitable gift be directed to the next nearest charitable objective rather than to fail by reason of its immediate legal objective being unachievable. Expansion of this was perhaps because of the Chancellor being inventive as well as benevolent.

Professor H. F. Jolowicz,<sup>173</sup> an authority on Roman law, observed that the doctrine was known to the Romans, and that its infiltration into English law seems likely to have had a Canon Law base.<sup>174</sup> In that connection, Gareth Jones<sup>175</sup> observes that "it is known that the ecclesiastical courts did apply property *cy-pres* where particular charitable purposes could not be accomplished", and Jones further notes that "by the beginning of the 15<sup>th</sup> Century the testamentary jurisdiction of the ecclesiastical courts (which only ended in Victorian times with the Court of Probate Act 1857<sup>176</sup> which finally transferred administration of persons estates to the lay courts on 11<sup>th</sup> January 1858) had become unpopular with the laity" by reason of fee

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99/100) describes its current reality and its origins from legislation by Henry VIII following the dissolution of the monasteries (1536-1540) and that sovereign's modification of the then law relating to advowsons and exemption from the Human Rights Act 1998 (1998, c.42).

<sup>173</sup> H. F. Jolowicz, *Roman Foundations of Modern Law* (Oxford: Clarendon Press, 1957).

<sup>174</sup> The latter being demonstrably founded on the Emperor Justinian inspired *Corpus Iuris Civilis*, and later Roman law.

<sup>175</sup> Gareth Jones, *History of the Law of Charity 1532-1827* (Cambridge: Cambridge University Press, 1969).

<sup>176</sup> (20 & 21 Vic., c.77).

levels and corrupt officials, and complainants turned to the Chancellor for relief by way of petition “to compel an executor to carry out a private or charitable legacy. Fifty years later...the Chancellor’s testamentary jurisdiction appears to be established...as a jurisdiction over the charitable legacy which remains concurrent with that of the bishop.”<sup>177</sup>

Elderly care was also bound up with poor law provision and the legal jurisdiction connected with the ecclesiastical court in England in the thirteenth century and it seems that prior to that various officials appointed by the bishop, or the bishop himself, utilised the power to adjudicate.

Brian Outhwaite<sup>178</sup> has identified a specialist and distinct court dealing with probate, marriage and divorce, tithes, defamation and disciplinary prosecutions involving the laity. This dates from the 16<sup>th</sup> Century and shows how influential canon law had become in developing solutions to common problems.

R. H. Helmholz argues that Roman law and its study was also more common then in legal education. “For many, the best course came to be to secure at least some training in both laws. Ambitious and learned men became *doctors utriusque iuris* if they could. The effects...were felt...throughout Western Europe, including England, and welcomed by the literate population...”<sup>179</sup> who in English medieval times were almost exclusively educated in the monasteries or...the church institutions until learning diversified into the earliest universities in England, notably Oxford, where teaching began in 1096, and in Cambridge in 1209.

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<sup>177</sup> Gareth Jones, *History of the Law of Charity 1532-1827* (Cambridge: Cambridge University Press, 1969), 74-75.

<sup>178</sup> B. Outhwaite, *The Rise and Fall of the English Ecclesiastical Courts, 1500-1860* (Cambridge: Cambridge University Press, 2006).

<sup>179</sup> R. H. Helmholz, *The Oxford History of the Laws of England* (Oxford, Oxford University Press, 2004), 59.



Roman law carried with its study education in moral and ethical values that were indicative of the established church after the link with Rome was severed following the Reformation.

Historically the functions performed by the Chancellor under each successive sovereign went through successive changes during and after the reign of Edward I (1272-1307) by virtue of the *Curia Regis*, starting the practice of referral of some civil appeals to the Council (the criminal ones being referred to the appropriate common law court) over to the Chancellor and his assistants, by virtue of their legal learning as churchmen. A strong probability is that such learning was Canon Law based.

During the fourteenth century successive Chancellors developed their quasi-judicial (and eventually fully judicial) role, and emerged that very significant body of English law known as equity and trusts, as well as that body of law known now as 'equitable relief' being primarily the remedy of the injunction.

As far as the ecclesiastical courts' jurisdiction is concerned, it is understood to have revolved around actions for probate for personal estates, non-contentious grant of probate, defamation, and gifts *inter vivos*. Later they extended into bankruptcy and some other personal issues such as marriage validity, but never openly the land issues which were the preserve of the temporal common law courts.

Helmholz observes that "...a common reason why estates were bankrupt was the *inter vivos* gift. Men gave away all they owned while still alive. Good reasons for doing so might have existed, quite apart from a natural desire to spare survivors the expense of probate administration."<sup>180</sup>

One was a trust-like arrangement:

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<sup>180</sup> *Ibid*, p.104.

*“a man or woman would receive all the goods of a person who could no longer care for himself in return for a promise to provide that care until the person died. Others were simply gifts to the natural takers of a man’s estate. The ecclesiastical courts did not oppose these and other gifts like them, although ... always required them to be proved, typically by showing a deed of gift.”<sup>181</sup>*

Testamentary charitable bequests for the elderly fell with the jurisdiction of Roman law influences.

Finally, trust law is important to the delivery of elderly care. In the earliest medieval times the Chancellor would be petitioned for relief against the application of a severe common law rule. Helmholz notes the frequency with which English ecclesiastical courts made use of “trust-like” devices.

Whilst some trusts issues, such as separation of legal from equitable title, played no apparent part in the ecclesiastical law or practice, “...management of property by one person for...another was a regular part of the law administered by the spiritual courts of the land.”<sup>182</sup> The possession of property to which fiduciary duties were attached was a natural part of this jurisdiction.

Most spiritual offices and much ecclesiastical property were held subject to a duty to preserve the corpus for the future, something like the Roman law *fidecommissum*, where the concept of *fiducia* came into play.<sup>183</sup>

Elderly persons were certainly engaged in estate planning for it is primarily in the testamentary field that the ecclesiastical court appears to engage this process, including administering bequests for minors from elderly relatives.

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<sup>181</sup> *Ibid*, p.105.

<sup>182</sup> *Ibid*, p.111.

<sup>183</sup> *Ibid*, p.113.

Helmholz also notes how this system worked as follows:

*“property bequeathed to children was routinely delivered to their personal representatives or guardians to be held and used for their benefit.....Guardians were subject to continuing supervision and control by the courts, as in a case where, it was alleged, the guardians had received £100 in revenues from trust property but they had spent nothing whatsoever on the intended beneficiaries.”<sup>184</sup>*

Amongst the enforcement mechanisms available to the court was the ‘draconian’ one of excommunication, thereby rendering the person cut-off from membership of the Roman Church and receipt of its sacraments, particularly the sacrament of “extreme unction” rendered to dying people, which jurisdiction appears to have succeeded.

This court’s jurisdiction also has circumvented the common law<sup>185</sup> prohibition of devises of land. Conveying land to feoffors, towards the end of the fifteenth century, could result in the Chancellor and later the Chancery Court enforcing against them the testator’s directions for that land.

### 2.3 Further statutory intervention

Elderly care is also linked to the role of charities. This has both common law and statutory rules. Early statutory intervention in the development of medieval charity law was required to prevent detect and address abuse of charities for

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<sup>184</sup> *Ibid.*

<sup>185</sup> Throughout this thesis ‘common law’ is used in terms of its initial Oxford English dictionary definition as “The part of English law that is derived from custom and judicial precedent rather than statutes” – [www.oxforddictionaries.com/definition/english/common-law](http://www.oxforddictionaries.com/definition/english/common-law). ‘Statutes’, the other primary source of law, unless otherwise indicated in a specific context, simply means Acts of the United Kingdom Parliament or its predecessors.

unlawful purposes.<sup>186</sup> Under Richard II, there is the Statute of Appropriation of Benefices 1391<sup>187</sup> to deal with apparent monastic generosity to themselves with benefices, and hence of tithes income, to the disadvantage of parishioners.

Thereafter the Statute of Enforcement of 1391, and a statute of 1402<sup>188</sup> under Henry IV soon became necessary. In the preamble to the Statute of Government of Hospitals 1414,<sup>189</sup> under Henry V, it was complained that, although donors had been very generous, the hospitals they had founded “be now for the most part decayed and the goods and profits of the same ... withdrawn and spent in other use, whereby many men and women have died in great misery for default of aid.” The statute ordered that they should be inspected and reformed where necessary.

It’s significant how the elderly are classified alongside other groups such as the poor, the impotent or dispossessed.

The Statute of Uses 1535<sup>190</sup> awarded the legal title of an estate to the person who had the use of it following abuse of charitable status, and abusers could no longer claim the protection of the Court of Chancery, but became subject to the courts of common law. For protection ownership and use had to be vested in a charitable trust.<sup>191</sup> The English Reformation timing of this ‘shift’ of jurisdiction is notable.<sup>192</sup> Also, an Act was passed in 1572<sup>193</sup> so that property transfers for the use of poor or aged in any hospital were validated instead of being voided at common law by reason of the transfer instrument incorrectly spelling a hospital’s corporate name.

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<sup>186</sup> (8&9 Eliz.2, c.58).

<sup>187</sup> (15 Ric.2, c.6).

<sup>188</sup> (4 Hen.4, c.12).

<sup>189</sup> (2 Hen.5, c.1).

<sup>190</sup> (27 Hen.8, c.10).

<sup>191</sup> Norman Alvey, *From Chantry to Oxfam* (British Assoc. For Local History – London: Phillimore, 1995).

<sup>192</sup> See below.

<sup>193</sup> (14 Eliz.1, c.14).

The Charitable Uses Act 1597<sup>194</sup> enacted further provision “...for the charitable relief of poor, aged and impotent people...” and that some of those “...lands, tenements and hereditaments, goods, leases and chattels have been and are still liable to be most unlawfully and uncharitably converted to...the gain of some few greedy and covetous persons”. The Lord Chancellor and bishops were directed to intervene and then to “...set down such orders judgements and decrees as the said good godly and charitable uses may be truly observed...”

The Charitable Uses Act 1601<sup>195</sup> in its long preamble addresses “...lands, tenements, rents, annuities, profits, hereditaments, goods, chattels, money and stocks of money...for the relief of aged, impotent and poor people...nevertheless have not been employed according to the charitable intent of the givers and founders thereof, by reason of frauds, breaches of trust and negligence...” The Lord Chancellor, bishops and others were authorised to intervene, in the same way as the 1597 statute.

It became the practice in these statutes to declare the existing common law in the preamble. The necessity for the 1601 statute was that the 1597 statute was clearly insufficient in terms of the effect of its regulatory regime so the “net” had to be widened in terms of the range of assets subject to charitable use management.

The 1601 statute is a defining statute. It had a strong influence for the centuries that followed provided the judicial basis of defining a core range of activities or objects considered to be legally charitable (but the lists in the preamble were usually recognised as not being exhaustive of all possible charitable objects or activities).

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<sup>194</sup> (39 Eliz.1, c.6).

<sup>195</sup> (43 Eliz.1, c.6).

The statute was repealed by the Mortmain and Charitable Uses Act 1888,<sup>196</sup> its preamble was retained as a definition of public charitable status until it was abolished by the Charities Act 1960. This gave use to the well-known public benefit test.<sup>197</sup> “Public benefit was the key to the statute and relief of poverty its principal manifestation...The 1601 Act adopted and perfected the commission procedure established by the 1597 Act. It was better drafted and more sophisticated than its predecessor.”<sup>198</sup>

## 2.4 The Reformation period 1534 and its impact on the administration of elderly care

The history of elderly care would not be complete without consideration of the reformation and its impact of the reformation on the administration of England cannot be underestimated. The events leading up to Henry VIII’s reformation legislation in 1534 are worthy of particular analysis for many reasons but in particular because the dissolution of the monasteries (1534-1540) displaced the Catholic Church and its structures. It caused the elderly and the sick in monastic care to be turned out into the streets and criminalised all Catholics thereby greatly diminishing their contribution to society until 1829.<sup>199</sup> Rigid political control of religion during this period and the virtual outlawing of dissent had a significant effect that created an enormous void in elderly care and other care provision, which permeated political, social and economic life at all levels of society.<sup>200</sup>

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<sup>196</sup> (51&52 Vict. C.42).

<sup>197</sup> *Scottish Burial Reform v Glasgow Council* [1968] AC 138.

<sup>198</sup> Gareth Jones, *Ibid* p.84.

<sup>199</sup> Roman Catholic Relief Act 1829 (10 Geo. 4, c.7) following partial relief in 1791 by 31 Geo.3, c.32.

<sup>200</sup> In partial parallel with the charity law events described above is the reformation during the reign of Henry VIII (1509-1547), which become entrenched and extended during the reign of his daughter, Elizabeth I (1558 – 1603). Some continuity of Henry’s Reformation continues with the short reign of his son and successor Edward

Social undercurrents for reform which accompanied the reign of Henry VIII are identified by Paul Slack.<sup>201</sup> Apart from the Christian charity ethic in relation to the poor there was social pressure for moral reform. “This was also an old theme, familiar in medieval sermons against idleness; but reinforced by ... a new revulsion against the dirt and disease as well as the indiscipline of the poor, a fear of contamination.” But were the issues paternalism coupled with benevolence or self-interest directed at curtailing potential criminals who would threaten the safety of the ruling class?

As an anti-plague measure, Henry’s Chancellor, Cardinal Wolsey, in 1517 initiated a campaign against beggars and vagrants, and amidst similar social pressures by 1531 the Statute Concerning Punishment of Beggars and Vagabonds<sup>202</sup> replaced a 1495 statute on the same topic and provided for whipping, instead of placing them in stocks as previously prescribed, and return to their birthplace of such offenders.<sup>203</sup> It also provided for justices, and others to licence the impotent, often the elderly, to beg.

By 1536 the Statute For Punishment of Sturdy Vagabonds and Beggars requiring them to be put to work when returned to their place of origin with provision for parish collecting of voluntary alms for the impotent.

Having the title “Defender of the Faith” from Pope Leo X in 1521 for Henry’s pamphlet accusing Martin Luther, a European church reformist, of heresy, Henry found himself by 1534 in opposition to the then Pope Clement VII for refusing to

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VI (1547-1553), including some significant statutory material, and thereafter the short reign of Henry’s oldest daughter as Mary I (1553-1558) witnesses some statutory reversal of Henry’s Reformation by way of her attempt to turn back to Roman Catholicism.

<sup>201</sup> Paul Slack, *The English Poor Law 1531-1782* (Cambridge: Cambridge University Press, 1990)

<sup>202</sup> (22 Hen 8, c.12).

<sup>203</sup> The return to birthplace concept is found as early as 1388 (in 12 Rich.2, c.7).

grant him an annulment for his marriage to his wife Catherine of Aragon, primarily for failing to give birth to a male heir.

His decision to break with the Church of Rome caused the Act of Supremacy 1534<sup>204</sup> to declare that he was “the only supreme head on Earth of the Church in England” and that the English crown shall enjoy all legal consequences from that change. In support he also had enacted the Treason Act 1534 which provided that anybody disavowing the Act of Supremacy was committing treason.

This fundamental legal change repealed “at a stroke” the provisions in Chapter 1 of the Magna Carta 1215 which had guaranteed the freedom of ecclesia anglicana to regulate its own affairs without permission or control from the king’s ministers.<sup>205</sup>

## 2.5 Institutional impact on elderly care

Through personal ambitions Henry VIII had thus displaced a system of Christian care delivery in the community to the elderly and the poor brought together by centuries of religiously inspired dedication and precipitated enormous social upheaval and consequent human misery. This gave state power priority and left an enormous ‘void.’ The 1601 Act remained in force but left care very much dependent upon the established church and state.

An institution of a local nature from an early date is the still functioning one of justice of the peace, which played a significant part for several centuries, as a

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<sup>204</sup> (26 Hen.8, c.1).

<sup>205</sup> Many years later when dissent became possible, a prominent Church of England churchman, John Henry Newman,<sup>205</sup> asserts in public debate, in the wider Christian context, that Henry’s political act lacks legitimacy. In terms of the English Church claiming to be acting as successors to the original Apostles of Christ. Persuasively, he questioned the church/state relationship in the context of the Church of England being part of an imperial power. *Church State and Society* – J. H. L. Rowlands (Bournemouth: Churchman Publishing – 1989).



system of local government and in the administration of relief to elderly impotent and poor people, and came into being as a statutory dynamic under the Justices of the Peace Act 1361.<sup>206</sup>

The enactment, which still endures until this day, provided that “in every county of England shall be assigned for the keeping of the Peace, one lord, and with him three or four of the most worthy in the county...with primarily criminal legal powers.” The national structure thereby put into place in 1361 not only provided a framework for administering criminal law but also a means of using subsequent statute to graft an administrative law system onto the holders of that office for poor law supervision purposes, including the implementation of the levy of rates at parish level, supporting the elderly and impotent in need.

The Justice of the Peace is an essential element in poor law delivery and in the administration of legislation enacted under the Tudors in the sixteenth century. Derek Fraser describes the justices of the peace as “the only effective local government system available.”<sup>207</sup>

## 2.6 Private Trust Provision

The importance of private trust provision is also significant. The definition of the legally enforceable arrangement between two or more persons, or other legal entities, known as a ‘trust’ is the subject of some controversy but in broad terms

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<sup>206</sup> 34 Edw.3, c.1 (Short title given by Statute Law Revision Act 1948 – Sch.1) (although a predecessor was the Statute of the Appointment of Justices of the Peace 1344 – 18 Edw.3, c.2).

<sup>207</sup> *The Evolution of the British Welfare State* (see below) – P.68.

embraced the concept of a party holding legal title to land or other property for the benefit of another.<sup>208</sup>

The durability of private lifetime and will trust provision in terms of its presence across the whole time spectrum of this study and is prolific use<sup>209</sup> in shaping its course through history<sup>210</sup> case law through the Courts of Chancery and the Chancery Division of the High Court<sup>211</sup> preventing a trustee from drawing profit from a trust.<sup>212</sup>

An early example of use of will trusts for charitable provision that includes elderly beneficiaries relates to the St. Giles' Norwich archives mentioned above. St. Giles, as a charitable hospital foundation, arose from the will trusts of Bishop Walter Suffield, Bishop of Norwich from 1244 to his death in 1257, his will having been made in 1249. The archives show that the original foundation charter was formally confirmed by Pope Alexander IV on 15 October 1257.

Private trust provision, particularly by way of will trust, is also evident in the post-Reformation period. The Eleanor Palmer Trust is one such example. This Trust arose from the provisions of the will of a lady who died in 1558 in Barnet, Hertfordshire, gave "...two acres of meadow land and its income for the benefit of the poor of Kentish Town and Chipping Barnet forever."<sup>213</sup> Subsequently, this charity brought the elderly within the scope of its objects, and this still exists today, and is

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<sup>208</sup> One judicially acknowledged academic authority, Underhill, stipulated "A trust is an equitable obligation, binding on a person (who is called a trustee) to deal with property over which he has control (which is called the trust property) ...for the benefit of persons (who are called the beneficiaries...) of whom he himself may be one, and any one of whom may enforce the obligations..." in the earlier Court of Chancery or any division of the modern High Court – approved and adopted in *Equity and the Law of Trusts* Second Edition (1970) Philip Pettit, Professor, University of Bristol (Butterworths:London)- Page 16.

<sup>209</sup> The author as a practising lawyer is still drawing them up after 30 years in practice.

<sup>210</sup> For example the Trusts of Land and Appointment of Trustees Act 1996 (1996 c.47).

<sup>211</sup> Since the Supreme Court of Judicature Act 1873 (36&37 Vict.c.66) and the Supreme Court of Judicature Act 1875 (38&39 Vict. C.77) came into force together and merged the administration of common law and equity into a single higher court.

<sup>212</sup> *Bray v. Ford* [1890] A.C. 44 H.L.

<sup>213</sup> [www.eleanorpalmertrust.org.uk](http://www.eleanorpalmertrust.org.uk).

charged with running a residential care home for 32 of the elderly at Spring Close in Barnet.

Another example that remains open today is the trust set up in 1674 on the death of Lady Katherine Leveson, with several charitable bequests, including the establishment of alms-houses adjacent to the parish church at Temple Balsall, Warwickshire. Initially for “20 poor widows or poor spinsters of good lives...A minister was to be found to read the Scriptures twice a day and to instruct the women for the good of their souls, and he was to have £20 a year for this service.”<sup>214</sup>

In due course the category of Leveson beneficiaries was to include aged men and women, and it is a remarkable tribute to that testatrix that the Foundation bearing her name is still functioning at Temple Balsall today in a strong Christian tradition, and primarily for the care of the elderly.<sup>215</sup>

The legal developments and structures outlined above do begin to merge into a hotch-potch of statutory law that eventually became known as the English “poor law.” Below is a review of the more significant earlier statutory activity in this process.

The 1388 enactment of the Statute of Cambridge,<sup>216</sup> directed at control of the movement of labourers and beggars, provided additional powers for justices of the peace<sup>217</sup> to deal with “sturdy beggars” capable of work and distinguish them from “impotent beggars” incapacitated by age or infirmity, and for each “hundred” (geographical division) in each county to be responsible for housing and keeping its own paupers. Regulating of labour also included the aged and impotent.

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<sup>214</sup> [www.leveson.org.uk](http://www.leveson.org.uk).

<sup>215</sup> The current minister discharging that task is the Reverend Kathy Lloyd-Roberts, interviewed for the purposes of this study.

<sup>216</sup> (12 Ric.2, c.7).

<sup>217</sup> See 1361 statute *Ibid*.

Fraser observes that the two statutes were a “paternalistic attempt to introduce wage control...and to prevent that mobility of labour which would cause wages to rise.”<sup>218</sup> Laws against vagrancy were thus the origins of *poor relief*, and whenever economic conditions prevailed which encouraged men to wander the country in search of employment, the late medieval and early modern English state sought to restrict this mobility for fear of its social consequences.” This form of social provision reformed the feudal system, albeit in a benevolent way.

Later, with the advent of the Industrial Revolution at the end of the eighteenth century, there was a shift from towns and villages to urban centres.

A statute of 1494<sup>219</sup> was directed at punishing vagrants and required them to resort to the hundred where they last dwelled,<sup>220</sup> and permitted beggars too infirm to work to remain in their hundred and continue begging, the subsequent statute Concerning Punishment of Beggars and Vagabonds 1531<sup>221</sup> dealt with a change in the punishment of vagabonds and added a provision for licensing of impotent persons, including the elderly, to beg, such licenses being obtained from justices, town mayors, bailiffs and others.

These measures continued to enforce the system of social control and feudalism. Elderly care was mixed with the general care for the poor, unemployed or dispossessed.

By 1536 another statute For the Punishment of Sturdy Vagabonds and Beggars<sup>222</sup> is required to deal with vagabonds returned to a parish (under previous

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<sup>218</sup> Derek Fraser, *The Evolution of the British Welfare State - A History of Social Policy since the Industrial Revolution* (London: Palgrave Macmillan, 2003), 274.

<sup>219</sup> (11 Hen.7, c.2).

<sup>220</sup> i.e., that sub-division of the shire county.

<sup>221</sup> (22 Hen.8, c.12).

<sup>222</sup> (27 Hen.8, c.25).

“return to place of origin” legislation which eventually becomes contentious between parishes trying not to inherit responsibility for a particular person.

This statute also implemented a system for collection of voluntary alms by churchwardens and others for the benefit of “impotent persons,” as a statute for the dissolution of the monasteries left a void to be filled by state provision and local government.

The 1547 statute For the Punishment of Vagabonds and Relief of the Poor and Impotent Persons<sup>223</sup> was a permanent public provision for the impotent, amongst others, and came with a statute For the Provision and Relief of the Poor in 1552.<sup>224</sup>

The legislation accompanied a system of collectors of alms in every parish. It also required accounts, compiling of a register of collectors and the impotent poor on relief, and a prohibition against begging. This system is the enlarging of a publically funded poor person’s social welfare programme.

Fraser notes that two economic processes occurred during the sixteenth century which “...swelled the numbers of those without subsistence.”<sup>225</sup> First, there was the process of enclosure which largely involved the conversion of arable land to pasture and produced widespread depopulation, the extent of which is a matter of debate. Second, there was the massive inflation, the so-called ‘price revolution’, consequent upon the import of precious metals from the New World.”

Elderly care is intertwined throughout in the system of general poor law relief. Further refinement appeared in the statute For the Punishment of Vagabonds and for

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<sup>223</sup> *Ibid.*

<sup>224</sup> (5 & 6 Edw.6, c.2).

<sup>225</sup> *Ibid*, p.277.

Relief of the Poor and Impotent 1572<sup>226</sup> changing the punishment for vagabonds and directing justices of the peace to register the names of “aged, decayed and impotent poor,” decide how much they require and assess all the inhabitants to contribute weekly to their relief, on pain of their committal to gaol.

## 2.7 State intervention and religious organisations: The Hospitals for the Poor Act 1597<sup>227</sup>

One of the most significant statutes of this period is the statute of Elizabeth I that followed in the wake of the Disabled Soldiers Act 1592<sup>228</sup> which former Act had permitted bequests of land and buildings to establish “houses of correction or abiding-houses” for the poor or for maimed soldiers but it was still not possible to establish a hospital without a specific royal grant so the 1597 Act brought in a system allowing any person wishing to establish a foundation to create it by deed at the High Court of Chancery and such a foundation would achieve permanence.

Such was the effect of this 1597 Act in helping to put in place the post-Reformation hospital structure that it was not repealed until 1960.<sup>229</sup> It is noticeable how the differing parts of the system came together: the justices of the peace, the church wardens, and the poor.

The direct role of Justices of the peace acting as assessors changes with the Statute For the Relief of the Poor 1598<sup>230</sup> when the primary tasks are put upon churchwardens and four overseers in every parish, including taxation of “every

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<sup>226</sup> (14 Eliz.1, c.5)

<sup>227</sup> (39 Eliz.1, c.5)

<sup>228</sup> (35 Eliz.1, c.4)

<sup>229</sup> The whole Act was repealed by Section 39(1) of, and Schedule 5 to, the Charities Act 1960 (8 & 9 Eliz.2, c.58) [www.legislation.gov.uk/ukpga/1960](http://www.legislation.gov.uk/ukpga/1960).

<sup>230</sup> (39 Eliz.1, c.3).

inhabitant and occupier of lands” in the parish for these and related purposes, and even tax some parishes to help others.

The law was generally ingenious in providing different solutions. Levying distraint on the goods of those refusing to pay is the remedy, and justices in county or quarter sessions<sup>231</sup> hear appeals against rating assessments. Other provisions related to setting the poor to work, and putting out poor children as apprentices.

Lorie Charlesworth explains how the system gave rise to the introduction of a power to tax surrounding parishes:

*“....this authorises a poor law system that is ... bound to relieve all who qualify and are in need...Two justices could issue a warrant for distress for failure to pay the rate and if distress fails the defaulter is to be sent to prison without bail until payment is made. The same fate awaited churchwardens and overseers who refused to account to the justices. Poorhouses were to be built and land for (them) obtained from and with the consent of the Lord of the Manor...Section 6 of the Act sets out...for the first time; that parents and children of the poor ‘being of sufficient ability’ have a duty to maintain the same...”<sup>232</sup>*

Paul Slack<sup>233</sup> found that “by 1600 most of the larger towns seem to have had poor rates...but only a small minority of rural parishes...The decisive move towards the widespread implementation of the law came only after 1601, helped by pressure from the centre, through assize judges lecturing magistrates who in turn used constables to stir a parish response.” Thus assize judges having been continuously in place, travelling the country on circuit since the 12<sup>th</sup> Century and no doubt having

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<sup>231</sup> *Ibid.* Another long survivor with assize courts until the Courts Act 1971 created the crown courts system.

<sup>232</sup> Lord Charlesworth, *Welfare's Forgotten Past* (London: Routledge-Cavendish- 2010) p.55.

<sup>233</sup> Paul Slack, *The English Poor Law 1531-1782* (Cambridge: CUP 1990), 35.

a strong influence, and indeed authority, over the justices of the peace in most parts of the realm since the 14<sup>th</sup> Century there had effectively existed central control via the judicial system for many years.

Arguably, the very motive behind the Assize of Clarendon 1166<sup>234</sup> on the part of Henry II was expansion of royal control in a world where the administration of ecclesiastical law and the wealth and independence of the Church deprived the monarch of much jurisdiction.

Complexities relating to the concept of “settlement,” namely the provisions which determine the place of origin or other place to which a person in need can claim to belong, were codified in an Act for the Better Relief of the Poor in this Kingdom 1662.<sup>235</sup>

The “settled” poor of any place are entitled to share in funds raised by the poor rate of that place and the acquisition of “settled” status by renting a tenement for 40 days, with a right of appeal to quarter sessions.<sup>236</sup> The statute, interestingly, makes mention of continuation of the London Corporation of the Poor.

## 2.8 Conclusions

In this chapter, the early historical foundations for elderly care have been explained. The principal finding is on resource provision, namely that beyond the family in earlier times lay a large range of care provision from religious groups and charities and little state involvement except for occasional legislation for others to follow.

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<sup>234</sup> (12 Hen. 2, c.3).

<sup>235</sup> (13 & 14 Car. 2, c.12).

<sup>236</sup> The 1388 statutory concept (*Ibid*) had clearly moved very much onwards.



Elderly care was delivered by many families with monastic and other charitable aid up to the Reformation, and in the post Reformation period, Elizabethan statutory structures and practices provided care and support, as of personal legal right, to paupers able to demonstrate that entitlement funded by the local levy of rates on property as part of a long lasting local government framework. This framework broadly lasted until it and the entitlement to be relieved were abolished by the Poor Law Amendment Act 1834.<sup>237</sup>

Outside the wealthy or landed classes resulted in limited needs for full scale State provision. Elderly care for those that survived was limited but bound up with common poor law provision for the poor, dispossessed and unemployed. Pre-reformation religious orders filled the gap and the influence of ecclesiastical and canonical rules took root. In many instances, private benefactions came to the fore. These were encouraged by Charity law and the creation of the Trust as a legal and economic instrument which gave support to many foundations and worthy organisations for the delivery of elderly care.

The chapter also traced how post-reformation England had to come to terms with gaps left by the “dissolution of the monasteries.” The State, both central and local, began to have a role for the delivery of elderly care and social provision. It is noteworthy how the jurisdiction of the Justice of the Peace became significant ‘local government’, and how poor law as a form of alms giving became more regularised. There are also some further thoughts. The absence of a coherent and well regulated system for elderly care is not surprising as the delivery of different forms of elderly

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<sup>237</sup> (4 & 5 Wm.4, C.76). - In total, the population of adults aged 65 and over living in (residential care) in England Wales rose from 8.3 million to 9.2 million over the decade, the figures show, with the contemporary life expectancy being 78.7 years for males and 82.6 for females - <http://ons.gov.uk/ons/rel/lifetables/national-life-tables/2010---2012/sty-facts-about-le.html>.

care by so many different institutions, families and local parishes left a vast array of delivery systems with no recognisable coherence. Elderly care rested on benevolence and the hierarchy of religious organisations to keep order and stability. Assumptions about doing good and caring for the old were never really challenged before the Reformation. The relief of distress and suffering covered a multitude of ills and the elderly were supported in a general way. This falls short of what was required or expected.

## CHAPTER 3: Elderly care in the 19<sup>th</sup> century to the development of the National Health Service

### 3.0 Introduction

Apart from enacting legislation the state's participation in the provision of elderly care during these times was via local authorities. Long ago it had become clear that families at common law had to take on responsibility for their elderly. Thus much was demanded of families and their resources.

As outlined in the previous chapter, the medieval influences in elderly care helped deliver care through support systems and religious zeal that had brought many in the voluntary sector to engage with caring for the elderly. The Elizabethan era had begun the creation of legal duties and obligations and fundraising at local parish level.<sup>238</sup> Medieval England and the feudal system developed a response to poverty and poor relief, the beginning of the breakdown of feudalism with the feudal lord's semi-philanthropic oversight of his workers having triggered the earliest poor law statutes. In Chapter 3, we turn to examine the contribution of the 19<sup>th</sup> century leading to the contemporary legal and regulatory framework relevant to elderly care today through the development of the Victorian workhouse and hospital institutions that later formed a core foundation in the creation of the National Health Service (NHS) after the second world war. It will be readily appreciated that the rudimentary framework for the NHS, including elderly care, came from many of 19<sup>th</sup> century

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<sup>238</sup> William P Quigley (Professor, Loyola University, New Orleans, USA), *Five Hundred Years of English Poor Laws, 1349-1834: Regulating the Working and Nonworking Poor (1997)* - [www3.uakron.edu/lawrev/Quigley](http://www3.uakron.edu/lawrev/Quigley). Also Lorie Charlesworth (Institute Of Advanced Legal Studies, University of London), *England's early 'Big Society': parish welfare under old poor law (November 1<sup>st</sup> 2010)* - [www.historyandpolicy.org/policy-papers](http://www.historyandpolicy.org/policy-papers).

developments. The two world wars interrupted these developments but served to reinforce the need for care of the most vulnerable.

The 19<sup>th</sup> century is remarkable for the influence of ideas and the transformative effects of an elected Parliament from 1832 based on a greatly extended franchise. There are many influences, but prominent amongst the philosophers and writers are three well-known names: Jeremy Bentham (1748-1832),<sup>239</sup> lawyer, philosopher and social reformer, and his student John Stuart Mill (1806-1873). The third is Bentham's former Secretary Edwin Chadwick (1800-1890), were prominent among many others in propounding their own brand of utilitarian secularism amongst many prominent thinkers of all religious views and none.

### 3.1 The 19<sup>th</sup> Century philosophical ideas and Influences on elderly care

In the 19<sup>th</sup> century, while elderly care became more identified as needing special attention, it remained under the same influences from philosophical thinkers, politicians, churchmen and others concerned with poverty and disease. Generally, care of the elderly was related to generic issues regarding poverty, health and the law. This was a reflection of the "patch-work of powers" with parish led local government often taking the lead role.<sup>240</sup> The mix-match of Church and Government was reinforced by a confusing mix of local Justices of the Peace, churchwardens and parishioners.

Land and premises rate payers were subjected to a poor rate and this paid for local relief. However, this was not in any way a voluntary arrangement and, on the

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<sup>239</sup> Michael Quinn, *The collected works of Jeremy Bentham-Writings on the Poor Laws Volume 1 & Volume 2* (Oxford: Clarendon Press, 2010).

<sup>240</sup> Cornish et al, Editors, *The Oxford History of the Laws of England Vol XIII* Raymond Cocks, "Part Two: Statutes, Social reform and Control" (Oxford: Oxford University Press, 2010), 537.

contrary, local parish vestries operated under the authority of legal duties and obligations enforced by the common law of England and Wales in which local communities were subject to sanctions for misconduct including failure to perform their pauper, including elderly pauper, support duties.<sup>241</sup>

As early as the Poor Relief Act 1722<sup>242</sup> parishes were permitted to provide houses where paupers, including the elderly, could be housed, supervised and put to work rather than relieved in their own homes, as a mandatory workhouse system to reduce financial abuse, but before the end of that century by the Poor Relief Act 1795<sup>243</sup> those suffering illness or distress could be relieved again at home using the Speenhamland<sup>244</sup> system of any wages earned by those paupers being subsidised up to subsistence level by a top-up from the rate levy. In theory, from 1782, parishes could come together for the relief of “the poor and aged,” but this did not always occur and the initiative was very much a matter for local consultation.<sup>245</sup>

Sometime after 1815, a crisis grew from farmers keeping wages low knowing that they had the subsidy, and labourers didn't need to work too hard knowing they and their families would always be supported.<sup>246</sup> Hence increased costs for the supplement grew so that while the population of England had doubled from 1760 to 1832, taxes for poor relief had risen 5½ times their 1760 level. By 1834, drastic reform to cut costs was critical, and political intervention, as it happened by a royal commission, was essential.

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<sup>241</sup> Lorie Charlesworth - policy paper, *Ibid*, p.2.

<sup>242</sup> (9 Geo.1, c.7).

<sup>243</sup> (36 Geo.3, c.23).

<sup>244</sup> Named after Speenhamland in Berkshire where the scheme was founded.

<sup>245</sup> Poor Relief Act or Gilbert's Act 1782 22 George III c.83.

<sup>246</sup> According to research by Professor William Quigley of Loyola University, *Five Hundred Years of English Poor Laws, 1349-1834:Regulating the Working and Nonworking Poor* (New Orleans, USA), 21 – [www3.uakron.edu/lawrev/Quigley](http://www3.uakron.edu/lawrev/Quigley).

The first half of the 19<sup>th</sup> Century has also been identified as an “Age of Atonement,” that is an evangelical reaction to a world apparently overtaken by wars, famines, floods and general commercial upheavals supposedly divinely motivated, thus setting the primary Christian mood forming a significant part of backdrop of the period.

Boyd Hilton’s analysis provides a helpful overview as it traces the intellectual development that represents the “mind of the middle and upper classes during a period of social and economic upheaval. Ideas were often individualised... but there was no consensus, but rather a “war of ideas” which left most thinking men ambivalent or torn between “incompatible opposites.”<sup>247</sup> It began with a period of upper and middle-class reaction against the French Revolution and English Jacobinism.

Thomas Malthus (1766-1834), a prominent cleric and scholar,<sup>248</sup> famously noted that the onset of war and scarcity in 1793-5 were permanent conditions of civilisation, supported by biblical authority,<sup>249</sup> and that the pressure of population on food supplies blighted all earthly prospects of happiness. According to Hilton amongst middle-class Anglican circles extreme evangelicalism spread rapidly from the mid-1820s onwards, thanks to economic alarms, Catholic Emancipation, constitutional crisis, cholera, and other ‘signs’ of an impending divine initiative, and helped to persuade potential leaders such as Gladstone, Stanley, Acland, Newman, Manning, and Robert Wilberforce towards the High Church.”<sup>250</sup> Moreover:

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<sup>247</sup> Boyd Hilton, *The Age of Atonement – The Influence of Evangelicalism on Social and Economic Thought 1785 - 1865* (Oxford: Clarendon Press, 1986).

<sup>248</sup> Malthus, T. R, *Principles of Population* (London: J. Johnson, 1798).

<sup>249</sup> ‘for they shall fall by the sword, by the famine, and by the pestilence’ (Ezekiel 6: 11).

<sup>250</sup> *The Age of Atonement, Ibid*, p. 10.

*“Moderates believed that ninety-nine out of a hundred events are predictable consequences of human behaviour. Governments should interfere with men’s lives as little as possible;... in a world...meant for trial and judgment. Extremists saw no such predictability and thought that those whom it had pleased God to place in positions of worldly influence should... control... society.”*<sup>251</sup>

The political philosophies of the day, says Hilton, were described as “political economy constituted as a central element in the manufacturing middle-class provincial culture of the period after 1770, a culture which tended to combine either Tory politics and evangelicalism or Whig/Radical politics and Unitarianism.”<sup>252</sup> And it was “The celebrated Glasgow preacher and pastor Thomas Chalmers,<sup>253</sup> Professor of Moral Philosophy at St Andrews since 1823 [who] was the main exemplar of [this] evangelical economics.”<sup>254</sup>

It was John Wilson Croker<sup>255</sup> who, in 1840, defended the utilitarian New Poor Law of 1834, saying “it is meet and right, and our bounden duty, to help the weak, and alleviate distress, as far as our means allow; but to tell the working classes that any power can relieve them from their state of want and dependence is to impugn...the dispensations of Providence, and to disorder the frame of society.”<sup>256</sup>

As Hilton observes, “A. C. Cheyne<sup>257</sup> [...] presented the Scotsman Patrick Brewster as an evangelical antithesis of Chalmers. Convinced that the national calamities were caused by inequality of wealth and by corporate rather than

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<sup>251</sup> *Ibid*, p. 16.

<sup>252</sup> *Ibid*, p. 38.

<sup>253</sup> 1780-1847.

<sup>254</sup> *Ibid*, p. 39.

<sup>255</sup> 1780-1857.

<sup>256</sup> *Ibid*, p. 93.

<sup>257</sup> 1924-2006.

individual sin, Brewster supported 'moral force' philosophy and compulsory poor relief. He joined with William Alison in attacking Malthus's 'infidel philosophy' and Chalmers's injunctions to 'give as little as possible' or 'nothing at all'...rather than hazard the increase of human suffering by feeding the hungry, they will peril their own immortality, by a wilful act of disobedience to God."<sup>258</sup>

As Hilton also asserts Chalmers appreciated keenly how manufacturing industry could degrade and demean, but commerce was capable of effecting a beneficial 'moral transition' in its practitioners for in order to succeed a merchant needs to have a good name, and he will behave well in order to get one. Thus, does God employ human selfishness to promote human virtue? Trusting and being trustworthy in turn breed habits and thoughts which leave their mark on the soul.

In the same vein, Gladstone reflected privately that belief was really a form of 'spiritual exchange' – the trading of time, thought, money, health, and influence for the inward gifts of God and the likeness of Christ."<sup>259</sup> Chalmers's influence on Gladstone, four times Prime Minister,<sup>260</sup> is clearly marked and acknowledged. According to Hilton:

*"George Grote"<sup>261</sup> provides an example of the way in which such psycho-epistemological concerns could affect economic thought. In 1819 Grote met James Mill and through him Bentham. James Mill's own meeting with Bentham in 1808...led him to...take up utilitarianism instead. Grote succumbed at once... and... into pseudonymous attack on natural religion...."*<sup>262</sup>

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<sup>258</sup> *Ibid*, p. 108.

<sup>259</sup> *Ibid*, p. 124.

<sup>260</sup> Firstly in 1868 and finally in 1894.

<sup>261</sup> 1794-1871.

<sup>262</sup> *Ibid*, pp. 168, 169.



Moreover, as Stefan Collini argues: “John Stuart Mill, author of ‘On Liberty’ is remembered for his protest, in the name of ideals such as ‘individuality’ and ‘self-cultivation’ against the coercive power of Victorian moralism, whether exercised by law or by opinion,”<sup>263</sup> including the basic need of individual freedom from state control.

A number of other influences are particularly noteworthy. The Society of Friends known as The Quakers, and other philosophies, had a major influence over care of the elderly. Relieved from potential criminal liability for non-adherence to the state religion by the Toleration Act 1689<sup>264</sup> there grew a merchant class which included many Quakers following a simple Christian lifestyle, and, interestingly, advocating the equality of women. Prominent members were devoted to social justice and equality and were involved in then developing areas of industry and commerce.

Edward Pease,<sup>265</sup> a Quaker, opened the Stockton and Darlington Railway, the first modern railway in the World in 1825. His son, John, became the first Quaker elected to Parliament in 1832. Other Quakers included Henry and Joseph Rowntree<sup>266</sup> owned a chocolate factory in York, and John Cadbury who founded another chocolate factory at Bourneville, Birmingham, and a third was founded by Joseph Fry in Bristol.

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<sup>263</sup> Stefan Collini, *Public Moralists – Political Thought and Intellectual Life in Britain 1850 – 1930* (Oxford: Oxford University Press, 1991), 68

<sup>264</sup> 24 May 1689 relieving dissenters such as Quakers, Presbyterians and Baptists (but not Catholics).

<sup>265</sup> 1857-1955.

<sup>266</sup> Two brothers of whom Joseph lived from 1836 to 1925. In 1904 Joseph Rowntree used his wealth and influence to establish charitable trusts, including the Joseph Rowntree Foundation, to ‘tackle the root causes of social problems rather than just treating their symptoms’. This body still functions nationally as a prominent charity promoting modern research and policy input into poverty, ageing and elderly care issues – [www.jrf.org.uk](http://www.jrf.org.uk).

All of these factory employers provided their workers with more benefits than most employers of their day. Their business success gave them considerable political influence in policy formulation, including their caring perspective towards retired and elderly former employees.<sup>267</sup>

Later in this chapter we see that as the Industrial Revolution gathers pace across the Nineteenth Century as a whole the effect of the vast expansion of the towns and cities drives the need for increased information gathering in general and population data<sup>268</sup> in the form of statistics in particular, to inform policy formulation and drive political change, such as that affecting disease and insanitation. The elderly are necessarily at the heart of this 'sea change'.

Elizabeth Fry,<sup>269</sup> of the Gurney family who owned part of Barclays Bank, was one prominent member in the earlier nineteenth century who, from her sincerely held religious belief as a Quaker, tirelessly promoted politically for prison, workhouse and other social reform and relief of poverty. From 1816, she began what became a strong influence on social reform particularly in respect of women and elderly women prisoners, but is also remembered for her opening in 1840 a training school for nurses and her programme inspired Florence Nightingale, who took a team of Fry's nurses to assist wounded soldiers in the Crimean War (October 1853 to February 1856).<sup>270</sup>

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<sup>267</sup> [www.bbc.co.uk/history/elizabeth\\_fry](http://www.bbc.co.uk/history/elizabeth_fry).

<sup>268</sup> The Census Act 1800 (41 Geo.3, c.15) had already established a population counting system for every 10 years starting in 1801 but the sheer volume of socio-economic and cultural structural change from the Industrial Revolution by the time of 1840 had driven the need to formulate a new approach via the Population Act 1840 (3 & 4 Vict, c.9) including the permanent official presiding over it, the Registrar General. The 1841 census implemented the new arrangements for each of the tenth anniversaries thereafter, commencing in 1851.

<sup>269</sup> 1780-1845.

<sup>270</sup> [www.howardleague.org/elizabethfry](http://www.howardleague.org/elizabethfry) and the Medical Act 1858 – (1858 c.90.).

Thus, she appears to have been involved in and part of the professionalisation of the nursing profession and its consequent effect on elderly and other care delivery in regulatory quality improvement terms, and probably, in turn, its catalyst as further regulation of the medical profession.<sup>271</sup>

Charles Booth,<sup>272</sup> a corn merchant's son born in 1840 of a Unitarian Christian family, was to become a powerful voice on the national and political stage for pension provision for the elderly as part of structured social reform. In the years to come, he was to play a part in membership of a royal commission looking specifically at the aged poor.<sup>273</sup>

In the same year that the Poor Law Amendment Act 1834<sup>274</sup> was being enacted by Parliament, the Royal Statistical Society<sup>275</sup> had its beginnings at a meeting in London on 15 March 1834 as The Statistical Society of London, "the object of which shall be the collection and classification of all facts illustrative of the present condition and prospects of society."

Later it founded various committees of its members to study many different aspects statistically of society. The 10 fellows in 1835 became 402 by 1838, and its acceleration to Royal Charter status in later Victorian years<sup>276</sup> is a tribute to its increasing importance as an invaluable tool of socio-economic and political policy review used by legislators and other politicians, royal commissions and many others.

This Victorian growth in statistical use was eventually to help to erode rather than erase as such perceptions by many of the poor as 'evil' and being responsible

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<sup>271</sup> In the form of the Medical Act 1858 (21 & 22 Vict, c.90).

<sup>272</sup> 1840-1916.

<sup>273</sup> <http://booth.lse.ac.uk>.

<sup>274</sup> (4 & 5 Wm. 4, c.76) – one of its primary drivers being a social reformer Edwin Chadwick (1800 – 1890).

<sup>275</sup> Later incorporated in this name by Royal Charter on 31 January 1887.

<sup>276</sup> By which time it had a library of 20,000 books - [www.history.mcs.st-and.ac.uk/Societies/Royal\\_Statistical.html](http://www.history.mcs.st-and.ac.uk/Societies/Royal_Statistical.html).

for their own state in society, and the elderly as an 'ailment.' Indeed, in life expectancy statistical terms alone the identity of those who are considered elderly as a result of the stage of life at which they have arrived is notable in terms of modern life expectancy today, and itself goes through a remarkable process of change through the Victoria era (1837–1901) alone, accompanied by a dichotomy between urban and rural regions of England and Wales.<sup>277</sup>

Later in this chapter, we see how respected specialists, in a culture and era of increasing general education, enabled social issues to be viewed in a different light.<sup>278</sup>

The shortcomings in administration of the poor law with its ratepayer support for the 'outside' pauper, and indoors workhouse paupers, was attended by an enormous diversity of interpretation and administration across the country which brought about an increasing tide of demand for reform in a radical sense.

The pressure brought to bear by various churchmen, such as the Rev. T. R. Malthus<sup>279</sup> and the Rev. Joseph Townsend,<sup>280</sup> as well as other people of high profile such as Sydney Smith,<sup>281</sup> led, in the wake also of some civil disturbances in 1832 to the appointment of the Royal Commission on the Administration of the Poor Laws.

This innovative use of the tool of the Royal Commission by the Whig Government of the day in itself set the pace for our modern times, in the year of

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<sup>277</sup> One academic study- *The decline of mortality in the nineteenth century; with special reference to three English towns* (October 1993)- Imogen Anderson of Durham University [www.theses.dur.ac.uk/5687/](http://www.theses.dur.ac.uk/5687/) gathers in graphic detail from several other academic studies dealing with life expectancy for the elderly and others and the eventual effects of policy change.

<sup>278</sup> Even the year before the 1834 poor law reforms the Factories Act 1833 (1833, c.63) for regulating and restricting child worker abuse had provided for compulsory responsibilities on mill owners to educate certain of their child workers as a piecemeal measure of incremental education provision until the very comprehensive Elementary Education Act 1870 (1870, c.59) became the first comprehensive statutory educational milestone.

<sup>279</sup> 1766-1834.

<sup>280</sup> 1739-1816.

<sup>281</sup> 1771-1845.

enactment of the Representation of the People Act 1832,<sup>282</sup> which itself was passed in the wake of serious public disturbances.

The 1832 Royal Commission was established in the year of the death of Jeremy Bentham, the radical scholar, barrister and philosopher of great fame who over the past several decades had propounded new thinking amongst the educated classes on a great spectrum of issues of politics, economics and law, and in particular the utilitarian philosophy, developed from his studies of Joseph Priestley, that “the proper objective of all conduct and legislation is ‘the greatest happiness of the greatest number.’”<sup>283</sup>

Bentham is known to have written in 1797-8 a detailed plan for reform of the poor law, his utilitarian philosophy engaging further issues affecting the elderly in the general pauper management scheme of things. These included government not meddling in people’s behaviour, unless it was causing harm to others. This non-religious thought process included freedom of elderly people, and even their tiresome relatives, to use euthanasia rather than face up to elderly decrepitude.<sup>284</sup>

Three works in particular addressed such current social issues, entitled ‘Pauper Management Improved’, ‘Situation and Relief of the Poor’ and ‘Outline of a work entitled Pauper Management Improved.’ The Population growth and urban expansion which Bentham witnessed caused him to think in terms of large scale solutions.

As Michael Quinn states: “Bentham proposes the provision of poor relief by 250 Panopticon Industry Homes, each accommodating 2000 people, owned and

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<sup>282</sup> (2&3 Wm 4, c.45).

<sup>283</sup> [www.ucl.ac.uk/Bentham-Project](http://www.ucl.ac.uk/Bentham-Project) - A philosophy which in terms of followers such as his secretary, Edwin Chadwick, and his student, John Stuart Mill, and many others was to leave after him a great ‘legacy’- [www.spartacus.schoolnet.co.uk](http://www.spartacus.schoolnet.co.uk).

<sup>284</sup> Michael Quinn, ed., *Writings on the Poor Laws, Vol.2 (The Collected Works of Jeremy Bentham)* (Oxford: Clarendon Press, 2010).

managed by a joint-stock company, the National Charity Company. The dependant poor were to be occupied primarily in the production of their own subsistence, while the Company's viability depended on the indenture until the age of 21 of a rapidly expanding number of children, whose relative productivity would cross-subsidise the provision of relief to the sick and the elderly."<sup>285</sup>

Central to Bentham's Panopticon architecture<sup>286</sup> was a design whereby the pauper inmates were located in a space that placed their conduct at any moment under the "inspection" or surveillance of others, and it be accompanied by a new system of comprehensive record-keeping.

Bentham's philosophy only needed to await the political change when Earl Grey's Whig party, with some radically inspired members, got into power.

Significantly, Bentham was the mentor of his secretary, Edwin Chadwick,<sup>287</sup> whose role, technically, as Secretary to the three man Commission, was to prove to be their driving force, and the most important individual proponent, of the Poor Law Amendment Act 1834.<sup>288</sup>

S. E. Finer<sup>289</sup> describes Chadwick's personality as "aggressive" and his background as including lack of success as a criminal law barrister who turned to the civil service when social problems were rife from industrialisation and urbanisation. He associated with high profile economists, lawyers and other strong thinkers of the day, and was a friend of the philosopher John Stuart Mill.

In this climate of change the Prime Minister Earl Grey announced in February 1832 a Royal Commission "for enquiring into the administration and practical

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<sup>285</sup> Michael Quinn, ed., *Writings on the Poor Laws, Vol.2 (The Collected Works of Jeremy Bentham)* (Oxford: Clarendon Press, 2010).

<sup>286</sup> Itself based upon Bentham's earliest plan for a panopticon prison, which politicians did not take up.

<sup>287</sup> S.E. Finer, *The Life and Times of Sir Edwin Chadwick* (London: Routledge/Thoemmes Press, 1997).

<sup>288</sup> (4&5 Wm 4, c.76).

<sup>289</sup> Finer, *Ibid*, p.47.

operation of the Poor Laws.” The three commissioners included Nassau Senior, a friend of Chadwick, who in turn appointed Chadwick an assistant commissioner to look at the working of the poor law in London.

Finer asserts that Chadwick had a strong influence on Nassau, and despite Chadwick’s London remit, the eventual report via assistant commissioners allocated across the country was too focussed on rural issues and largely failed to address those involved in current urban industrial poverty.<sup>290</sup>

The Commission’s overall remit was to look at a system consisting of some 15000 parishes, most involving some elderly care pauper component of ratepayer support, coupled with the 18<sup>th</sup> Century workhouse system, where no central system of control was in place, and in the wake of earlier committees of enquiry and even a Select Committee of the House in 1817 none of which had generated reform.<sup>291</sup>

Specific issues of principle which Finer describes as facing the Commission related to the allowance system which attracted the able-bodied pauper from the main labour market so that free market labour competed against labour subsidised by the parish where pay levels were according to individual need, lack of central control and inconsistencies across the administration of the existing system using magistrates and overseers.

Chadwick, whom Finer finds to have strongly influenced the whole Commission through Nassau Senior, eventually produces his “Notes of the Heads of a Bill” in which he formulated his conclusions and proposals, and by lobbying influential members of both Houses of Parliament and using sympathetic sections of the press with whom he had great familiarity, he generated a tide of support.

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<sup>290</sup> Fraser, *Ibid*, p.48.

<sup>291</sup> Fraser, *Ibid*, p.51.

At the core of his proposals were a new re-modelled workhouse, with its constant inspection component, with a test structure to induce pauper labour to seek the free market, and a new central agency whose professional management of the national system would displace corruption at local level, with magistrates' involvement. Boards of guardians would oversee the system in localities. The new central authority would consist of three equal commissioners sitting as a permanent Board and separate from the legislature. This body was to be free of judicial review and free of the potential political pressure of ministerial control.<sup>292</sup>

In the workhouse envisaged by Chadwick, "its food was to be nutritious, its ventilation and accommodation vastly superior to that of the independent labourer... when one compares it with Panopticon<sup>293</sup> one is struck by the many resemblances...the wearing of workhouse dress, the rule of silence at meals."<sup>294</sup>

As contemporaries following Bentham's utilitarian philosophy from Bentham's 1832 death, Chadwick and John Stuart Mill carried forward Bentham's positive views on elderly euthanasia<sup>295</sup> as a free persons option to avoid decrepitude, inevitably meeting strong religious opposition.

### 3.2 The Poor Law Amendment Act 1834

As we have seen under the post-Reformation years of the right to be relieved, including the relief of many elderly persons, a growing economic crisis which had several aspects, but included the supplement of income system becoming too great an economic burden on the ratepayer, triggered the need for reform. This included the need to deter the volume of users of relief, by stringent measures, the effects of

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<sup>292</sup> A potential challenge indeed to the collective executive will of any national political administration.

<sup>293</sup> Bentham, *Ibid*, p.77.

<sup>294</sup> Finer, *Ibid*, p.55.

<sup>295</sup> John Stuart Mill, *On Liberty* (1859) - ed. Gertrude Himmelfare (London: Penguin, 1985), 83-84.



which on the elderly were in many cases to prove too drastic, but stigmatising the poor was a legislative reflection of common moral assumptions about poverty being the fault of the individual who was poor.

In the then existing workhouse system, those 'indoor' paupers were of course already earning their own keep. Accordingly, the Act implemented abolition of the existing system of low wage supplement for workers, the prohibition of 'outdoor' relief so that all relief must take place within the new workhouse in each parish or group of parishes, and workhouse conditions were designed to make them less preferable than those of the lowest paid outside labourer. In addition segregation of different classes of pauper now applied, so that married couples and families were split up.

The Poor Law Report of 1834 to Parliament, substantially compiled by Chadwick and Senior, became the substance of the 1834 Act. Finer notes that the Act "appears to have been modelled by Chadwick on friendly societies regulation" and it "contained no directions as to how relief was to be regulated, so absolute power went to the Board."<sup>296</sup>

The strategy for implementation of the Act across England and Wales was hampered by severe social and economic recession challenges,<sup>297</sup> so that limited success in the south of the nation was matched for some decades by substantial absence of implementation in the north, which experienced rioting as a direct result of this. By the time the legislation had its annual renewal in 1842, economic recession had arrived and the great driving force represented by Chadwick had redirected his energies into public sanitation.<sup>298</sup>

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<sup>296</sup> Finer, *ibid*, p.54. To the recently reformed House of Commons mind-set as a singular challenge to future political accountability, by itself.

<sup>297</sup> *Ibid*, p.54.

<sup>298</sup> *Ibid*, p.56.

Following a Commons committee report to the House in 1846,<sup>299</sup> the Poor Law Bill which followed proposed a new Commission as a Poor Law Board of ministers and a parliamentary secretary, accountable directly to Parliament.

A summary of the committee's findings were that the creation by the 1832 Act of a virtually autonomous statutory authority only indirectly accountable to Parliament on such an important social and administrative issue, not subject even to judicial review, was erroneous and not functioning properly. Fraser notes "The Poor Law was saddled with the paradoxical aim of alienating its potential clientele and the stigma of pauperism induced a reluctance to seek official relief" which became firmly rooted in national culture.<sup>300</sup>

In practical terms the recorded experiences of the elderly in the post 1834 workhouse shows that even married elderly couples were kept apart so that they could not have children, and after basic segregation on gender grounds the old, insane, slightly unbalanced and fit were kept together day and night doing nothing if they were not working. Also the buildings were stark, prison-like structures, and any sick or elderly person housed on the upper floors would virtually be a prisoner in the shared ward because of inability to negotiate the stairs.<sup>301</sup>

However, this familiar modern day perspective of the new poor law workhouse can give a distorted perspective of the elderly experience in the 19<sup>th</sup> Century. For example, Charity Commission records show that from the seventeenth and eighteenth centuries, large amounts of personal wealth were invested in charitable

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<sup>299</sup> Select Committee Report on the Workings of the Commissioners of the Poor Law 1846. As a result of a scandal at Andover, Hampshire.

<sup>300</sup> Fraser, *Ibid*, p.56.

<sup>301</sup> *Conditions in the Workhouse* – [www.historyhome.co.uk/peel/poorlaw](http://www.historyhome.co.uk/peel/poorlaw)

foundations, much of which went towards building almshouses and funding pensions for the aged poor.<sup>302</sup> Those elderly were demonstrably not poor law pensioners.

Data also demonstrates only up to a tenth of the nineteenth century elderly experienced the workhouse, and poor law financial support in their own homes or the homes of other family members was apparently successfully taking place, with occasional extra public funds for further support such as nursing.<sup>303</sup>

A network of voluntary hospitals in London and certain parts of the country is known to have emerged from the early nineteenth century based upon charitable provision for people above pauperism, and "...in many places the Poor Law authorities subscribed to these hospitals and used them for the treatment of paupers."<sup>304</sup>

The growing body of working people even before Victoria took the throne (1837) had begun the practice of clubbing together for mutual help at times of old age or ill health so that the increased funded use of these hospitals came about as well as other support arrangements. Thus, amongst various organisations, there emerged the friendly society. As early as 1834, for example, the Forester Friendly Society<sup>305</sup> had 300 branches throughout the nation.

As the reign of Victoria (1837 – 1901) progresses, life expectancy has also progressed but by no more than ten years, compared with a twenty year increase from 1901 to 1960,<sup>306</sup> and earlier in the Victorian period the rural elderly have a life expectancy of about 43 years and their urban counterparts are dying at between 24

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<sup>302</sup>By the early nineteenth century thousands of homes and pensions were available annually – [www.charitycommission.gov.uk/history](http://www.charitycommission.gov.uk/history). Also found in corroborating research – *The Welfare of the Elderly in the Past* (1991) David Thomson – essay in *Life, death and The Elderly- historical perspectives* M.Pelling and R.Smith (Eds.) (London: Routledge, 1994).

<sup>303</sup> David Thomson –essay, *Ibid*.

<sup>304</sup> Fraser, *Ibid*.

<sup>305</sup> [www.forestersfriendlysociety.co.uk](http://www.forestersfriendlysociety.co.uk).

<sup>306</sup> Thesis of Imogen Anderson, Durham University – *ibid*.

and 30 years until improved sanitation, sewerage construction and disease control in urban areas has taken effect towards the end of the Nineteenth century driven by statutory policy change.<sup>307</sup>

In terms of systems of what we now consider to be overall accountability, it seems that the harsh treatment and punishment culture inherited by the Victorians from their forbearers of earlier centuries, was undergoing a process of limited philosophical refinement to eliminate the “abuse of the elderly.” Whilst cultural and empirical evidence is present to demonstrate to the contrary, the perception of religious orders as above suspicion persists into modern times.

In addition to public and charitable bodies, care delivery was also capable of being delivered through the private incorporation of a company by registration as of right. This took place much later when the Companies Act 1844 with privileges conferred by the state in exchange for commercial transactions brought some limited statutory protection for creditors in respect of the maintenance of corporate capital.<sup>308</sup>

The main elements of the legal regulation of care were indicative of cultural and religious attitudes of the time that include the use of charity law, trusts, company law and contract law.

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<sup>307</sup> *The Report on the Sanitary Conditions of the Labouring Population of Great Britain* (1842) – Edwin Chadwick whose report findings in rural Rutland workers average life expectancy was 43.6 years, in Leeds 30 years, Liverpool 24 years, Manchester 25 years and Bolton 25 years.” This led to the setting up of a royal commission which led to the Public Health Act 1848”- [www.nationalarchives.gov.uk/education/victorianbritain](http://www.nationalarchives.gov.uk/education/victorianbritain)- findings corroborated by Imogen Anderson- *ibid*- who added: “A change occurred during the second half of the nineteenth century which allowed a previously high level of mortality to be redressed.”

<sup>308</sup> Currently the Companies Act 2006. 2006 c.46 (with its 1300 sections).

### 3.3 Conclusions

The legacy of the medieval period and the main social reforms of the 19<sup>th</sup> Century, outlined in Chapter 2 and discussed above has left an assortment of ill coordinated and poorly managed solutions to social, and particularly, elderly care. The workhouse and its social services delivery through various local authorities carried a multitude of responsibilities as well as catering for a vast variety of social needs. These varied from young and old, healthy and ill. Outdoor relief dominated the delivery of the needs of the poor. Elderly care was often found within general provision with specific alms houses and tenancies for older people, an ever expanding part of the overall population.

The elderly were slowly beginning to be recognised as distinctive although they were treated alongside the poor and vulnerable.<sup>309</sup> The elderly were not easy to accommodate in the workhouse mentality that marked out the Victorian experience. Setting aside special accommodation or care institutions relied heavily on religious orders and families. Voluntary elderly and other support via the pre-Reformation monasteries and churches were transformed by government into legal duties at the parish level. Elderly care is seen as a growing social need, reinforced by strong religious beliefs and concern for the frail and the aged.

There are some discernible trends that are clear from this period. Inspection is identified as important in Bentham's work. Care and poverty are being defined through statutory obligations rather than social obligation. Pension provision in 1908<sup>310</sup> is related to providing care for the elderly after their employment. Pre-Beveridge elderly care was partly seen in hospital provision, small private care

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<sup>309</sup> *Excerpts on Old Age- the Dialogues of Plato* – when passions are gone- Republic 1, Cephalus, on old age, to Socrates.

<sup>310</sup> By the Old Age Pensions Act 1908 (8 Edw.7, c.40).

homes and family commitment to look after their older relatives. Charity law had recognised the importance of bequests for the elderly and charitable and private trust law allowed estates to be settled, providing home for many elderly relatives. The first poor law statute recognisable as such is the Statute of Cambridge 1388<sup>311</sup>. We have seen that this provided support to the less fortunate in the form of the compulsory parish rate charge upon premises. This (narrow) paternalism from the state, long constrained by the religious views mentioned, remains continuous, in due course.

There is also an emerging sense of social and economic responsibility prevailing at the end of the 19<sup>th</sup> century. Also, long accompanying elderly care historic development had been the need for legal and social structures to be seen to be supporting the family 'burden' of elderly care provision. Thus as an important element of developing a strategic approach to elderly care, social policy makers have necessarily to engage a 'sharing social responsibilities' perspective.

The role of publicly funded statutory provision since long before the Elizabethan poor law was found to be inadequate and this began to give rise to changes in the system of public funding that were to become catalyst for change in the system of national insurance in the 20<sup>th</sup> century..

The role of nursing care is also being recognised in the aftermath of the Crimea War and the efforts of Florence Nightingale on professionalization of care. The Medical Act 1858 is an important stepping stone in the regulation of medical doctors.<sup>312</sup>

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<sup>311</sup> (12 Rich.2, c.7) – which made original provision in the wake of the Peasants Revolt of 1381 to separate into categories 'labourers and sturdy beggars' requiring them to work or face penalties such as the 'stocks', and 'impotent' persons, including the elderly, who were required to remain in their place of residence as at the passing of the Act but could receive voluntary charity.

<sup>312</sup> And in the contemporary political accountability context of Professor Julia Black's analysis and assessment of 2013 ('Calling Regulators to Account: Challenges, Capacities and Prospects', in *Accountability in the Contemporary Constitution*, ed. Nicholas Bamforth and Peter Leyland, (Oxford: Oxford University Press, 2013)).

## CHAPTER 4 - Elderly Care, the Beveridge Report and its aftermath

### 4.0 Introduction

The end of the 19<sup>th</sup> century and the beginning of the 20<sup>th</sup> Century were formative times for the delivery of a variety of 'care' arrangements by the state. The principle of universalism was emerging that everyone irrespective of age, status and wealth should have access to care is most significant. This is a period marked by the Beveridge report published after the Second World War but the foundations and ground work for Beveridge began much earlier. The elderly continue to be treated alongside the poor and sick but there are specific issues that emerge that are related to the elderly alone. In January 1909,<sup>313</sup> the first old age pension as a non-contributory state 'safety-net' for the aged over seventy years of age formed the vanguard of modern welfare state legislation. We have already noted how in the first half of the twentieth century publicly funded aid came from poor law relief. Aged and infirm persons were given residential homes in the many parish level workhouses. This appears to have been taken up by a small minority. It has been estimated that from the 1890s in-house care was provided by the state for only 4% of the age group<sup>314</sup>. Private charitable delivery and alms houses are also in evidence as elderly care began to develop its own distinctive character.

One significant 'piecemeal' development in 1929 is the municipal hospital system whereby local councils are empowered to take over and run the then existing poor law hospital system, funded by and for the benefit of their own ratepayers, but

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<sup>313</sup> By means of the Old Age Pensions Act 1908 (8 Edw.7, c.40) – passed by Asquith's Liberal Government.

<sup>314</sup> David Thomson, *Workhouse to Nursing Home: Residential Care of Elderly People in England since 1840*, Vol.3 (Oxford: Clarendon Press, 1983), 43-70.

the success of this varied from one local authority to another.<sup>315</sup> This also provided the basis for designated care for the elderly.

Ill health and elderly care came together in the general consideration of healthcare delivery with a universalism approach in the influential Beveridge Report. The embryonic national hospital structure had come into place before the Second World War, latterly through the work of Neville Chamberlain.<sup>316</sup> On the outbreak of war in 1939, Chamberlain, the then Prime Minister, who as Health Minister in 1929 had overseen the restructuring of local government welfare and hospital responsibilities,<sup>317</sup> introduced the war-time emergency hospital structure.

Two-thirds of British hospitals were co-opted within central and national control and influence. This set the stage for the Beveridge philosophy, “with the State as beneficial provider.” The war time expansion of State control generally was also a factor in defining the role of the State. Post-war Britain was devastated, with unemployment and poor social care.

The ‘twin’ 1948 reform with the implementation of the universal NHS right to free treatment at the point of delivery, especially to the elderly, in local government care delivery terms is the Local Health Authority (LHA) welfare structure and also the ‘safety net’ for those adults by reason of age, disability, illness, etc., in need of being accommodated to be provided with such free of charge by their local authority. This

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<sup>315</sup> By the Local Government Act 1929 19 & 20 Geo.5, c.17).

<sup>316</sup> A veteran innovator already by virtue of his piloting through Parliament both pensions and public infrastructure legislation, namely, the Widows, Orphans and Old Age Contributory Pension Acts 1925 (15 & 16 Geo.5, c.70), the Local Government Act 1929 (19 & 20 Geo.5, c.17) and the Unemployment Act 1934 (23 & 24 Geo.5, c.29).

<sup>317</sup> Chamberlain’s 1929 Bill which became the Local Government Act 1929 (19 & 20 Geo.5, c.17) abolished the poor law guardian system and transferred its public assistance and welfare functions, together with powers for local government to take over local hospitals, to local county and county borough councils. Elderly care provision, which was at the heart of these arrangements, was thus transformed into a less stigmatised delivery system.



is achieved by Section 21 of the National Assistance Act 1948,<sup>318</sup> and represents progression of local authority powers and duties primarily from the Local Government Act 1929<sup>319</sup>.

The first part of the chapter charts the rise and influence of the famous Beveridge Report in 1942. The second part covers the period leading to contracting out policies and considers their impact in elderly care in the 1980s. The period from 1983 to 1993 was important in establishing private residential and nursing homes largely paid for out of the Department of Health and Social Security under the NHS and Community Care Act 1990. This led to a peak of over 575,000 places in 1996.

#### 4.1 The Victorian legacy and the road to Beveridge in 1942

As outlined in the previous chapter, the Victorian legacy of limited but paternalistic care was an enduring one and the poor law had covered many aspects of care. As Fraser observes “the Poor Law medical service grew in response to the inadequacy of voluntary efforts in the wake of great urban population expansion. The key figure in delivery of healthcare at the local level was the office of the Poor Law Medical Officer, who gradually became a sort of general practitioner for the general poor.”<sup>320</sup> The steps leading to a truly national health service system, including the provision for the poor and elderly began tentatively. Gladstone appointed the first Royal Commission on the Aged Poor in 1893, which reported to Parliament in 1895.

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<sup>318</sup> (11 & 12 Geo.6, c.29).

<sup>319</sup> (19 & 20 Geo.5, c.17) – although other statutes since are of relevance in the process of increasing elderly care housing obligations, etc.

<sup>320</sup> Fraser, *Ibid.*

Its membership included Joseph Chamberlain and Charles Booth, both were prominent and dedicated social reformers.<sup>321</sup> Evidence from the Commission Report is available in the archives of the British Medical Journal.<sup>322</sup> The Commission was divided on its recommendations but a central and important finding was: "...despite growing national prosperity and a falling bill for poor relief, workhouses and poor law infirmaries were rapidly filling up with destitute sick old folk. Thousands more were reliant on their children for the basics of life."<sup>323</sup>

The main findings of the majority of the Commission were also that poor law guardians should be more discriminating so that poor persons, including the elderly, of good character, not previously ratepayer financially supported, should get that help. They concluded that the number of non-able bodied paupers had diminished significantly, indicating use of rising thrift within the working classes. Accordingly, there was no need for universal pension provision of the elderly, but private charities should be encouraged to provide 'deserving people' with pensions on a case by case basis.

However, old people's dependence on the poor law system was becoming a deeply unpopular and unacceptable indignity, hence triggering the need for the appointment of the Royal Commission. As reported in the BMJ, it states that:

*"Joseph Chamberlain and his 'pro-universal old age pension group' submitted an angry minority report, and five other members inserted disaffected agenda of dissent. To cap it all the commission's unfortunate chairman, Lord Aberdare, died the day before the report was published."*<sup>324</sup>

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<sup>321</sup> *Ibid.*

<sup>322</sup> [www.bmj.com/archive](http://www.bmj.com/archive). There is also archive material in the parliamentary papers for the commission and in the Public Record Office at Kew.

<sup>323</sup> *Ibid.*

<sup>324</sup> BMJ 1999,318:681 (editorial published 13 March 1999 – Elaine Murphy).

That minority also took the view that the Majority summary report was too optimistic, and its 'remedies' would do little to reduce old age pauperism.

Support for a national old age pension received a stimulus in 1899 when New Zealand introduced one. Accordingly in that year a Commons Select Committee was established, including Lloyd-George in its membership. Its report recommending non-contributory state pensions financed from taxation.

David Lloyd-George,<sup>325</sup> was in office in 1906 as President of the Board of Trade, Chancellor in 1908, and eventually Prime Minister in 1916.<sup>326</sup> Significantly, his successor as President of the Board of Trade in 1908 was Winston Churchill, and he and Lloyd-George were to drive progressive and active social reform policy as ministerial members of Asquith's two administrations of 1908 to 1916.

Lloyd-George, who had been President of the Board of Trade from 1905 to 1908 and had presided over its considerable expansion of its areas of responsibility, visited Germany in 1908 when Chancellor and witnessed the system of compulsory national insurance against sickness that began there in 1884. His visit coincided with a visit by William Beveridge who was in Germany in September 1907.<sup>327</sup>

Beveridge, who by 1908 is one of the leading authorities in the United Kingdom on unemployment insurance, was then to move into the Board of Trade as a senior civil servant in that year was allocated the responsibility of implementation of the labour exchange scheme.<sup>328</sup> The link between these two visits to Germany by two progressive thinkers was probably far from coincidence.

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<sup>325</sup> 1863-1945.

<sup>326</sup> None of which would have possible without the Representation of the People Act 1867, *Ibid.*

<sup>327</sup> Jose Harris, *William Beveridge - A Biography* (Oxford: Clarendon Press, 1977).

<sup>328</sup> To deal with "interruption of employment" on the part of workers, and, subsequently, administration of national insurance.

Indeed in his significant contribution to the setting up of the labour exchange system whilst at the Board of Trade, Beveridge was to make more than one visit to Germany and import German organisational experience into our structures (Beveridge having the advantage of being a fluent German speaker).<sup>329</sup>

One truly remarkable further historic fact from Beveridge's German visit, not appreciated by his biographer, is that he must surely have closely observed the functioning of the social reforms of Otto von Bismarck (1815 – 1898)<sup>330</sup>.

To gain political support for his unified Germany, which was far from straightforward, Bismarck introduced his Health Insurance Bill in 1883, initially to supply state-aided health for low income workers and state employees, followed by his Accident Insurance Bill 1884 and his Old Age and Disability Insurance Bill 1889.<sup>331</sup> By 1907 Beveridge would have seen comparatively mature systems in place, driven by the German 'efficiency' culture, and seen his future NHS for the United Kingdom.

Derek Fraser observes, "the spring of 1908 produced...the entry into Cabinet as President of the Board of Trade<sup>332</sup> of the youthfully exuberant Winston Churchill, who at this time was imbued with the cause of social reform...Churchill did not in the event introduce [the National Insurance Bill into Parliament in 1911 as by then he had moved to the Home Office. The scheme was well advanced before he left the Board of Trade."<sup>333</sup>

In Lloyd-George's 1909 Budget speech to the House of Commons he stated that the aim of the United Kingdom should be "...putting ourselves in this field on a

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<sup>329</sup> Jose Harris, *Ibid*.

<sup>330</sup> Prime Minister of Prussia (1867 – 1890), and first Chancellor of the German Empire (1871 – 1890), which Empire he helped to create by unifying the different states and principalities by triggering the Franco-Prussian War of 1870-1871- [www.bbc.co.uk/history/germany](http://www.bbc.co.uk/history/germany).

<sup>331</sup> Encyclopaedia Britannica (Kenneth Barkin) –Page 5 – [www.britannica.com](http://www.britannica.com).

<sup>332</sup> Lloyd-George's post since 1906.

<sup>333</sup> Fraser, *Ibid*, p.169.

level with Germany; we should not emulate them only in armaments.”<sup>334</sup> Thus, the increasing military strength of Germany, since Bismarck facilitated German unification in 1871<sup>335</sup> was also very much in the mind of many a British politician in terms of the future fighting fitness of our nation.

There was a wide recognition that state support of old age through pension relief would be a useful means to ensure that everyone could make provision for their old age, and hence the overall communal good. The Old Age Pensions Act 1908<sup>336</sup> was the result of a Bill promoted by Lloyd-George in the first Asquith (Liberal) administration of 1908 and made national provision for payment of pensions weekly by the State to persons of good character over 70 who were below a certain level of annual income. Payment was provided for from local post offices to avoid the stigma of “social welfare” from a government office as such.

This was a precursor of the National Insurance Act 1911.<sup>337</sup> Political engagement and co-operation with the friendly societies, the industrial insurance companies,<sup>338</sup> and the medical profession was critical, but as there was considerable scepticism about such legislation. House of Lords objections could only be limited to delay or amendment and not outright rejection after the passage of the Parliament Act 1911. The National Insurance Act 1911 marked a new shift in state intervention. Part 1 of the 1911 Act to provides for a compulsory unemployment insurance, sickness insurance, and health insurance scheme, contributed to by employer and employee, towards a national insurance fund, and topped up from general taxation.

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<sup>334</sup> Parliamentary Archives LG/C/26/1/2.

<sup>335</sup> Of its collection of principalities.

<sup>336</sup> (8 Edw. 7, c.40).

<sup>337</sup> (1 & 2 Geo 5, c.55).

<sup>338</sup> Prudential.

Free medical treatment was introduced for tuberculosis, and treatment by a panel doctor for sickness, with the doctor was remunerated on a *per capita* basis.<sup>339</sup> There persisted the question of compulsory measures for people to provide insurance for themselves rather than rely on the state for medicine and sickness benefits. Part 2 of the Act provided for certain industries to compel their workers to contribute to unemployment insurance under the control of their contract employment.

The authorship of, and architecture for implementation of, the National Insurance Act not only is attributable to Lloyd-George, Churchill and Beveridge. It helped that Beveridge “...found Churchill great fun to work with,” and “Beveridge had established a good working relationship with the Board’s permanent secretary, Sir Hubert Llewellyn Smith. Llewellyn Smith was a brilliant and rather domineering man, with considerable ‘inventive genius’ in the formulation of policy.”<sup>340</sup> Compatibility and cohesiveness of this rare combination was a powerful formula for success.

Beveridge, according to his biographer Jose Harris, only considered introducing national insurance of sickness by a breadwinner and its consequent interruption of his earnings as a beginning. Fragmentation of the system was clear. Social and medical care provision entitled the poor law, insurance and limited public health services. Dependents of the main breadwinner were left outside the existing scheme. The 1911 Act scheme was not state benevolence but removal of the inefficient, the sickly and the incapable in order to promote industrial prosperity and economic growth, and its success lasted until 1948.

At outbreak of the First World War in 1914 and the conscription of men into the armed forces revealed some stark realities. “One survey revealed that only one

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<sup>339</sup> As the NHS General Practitioner system does now.

<sup>340</sup> Jose Harris, *Ibid.*

in three conscripts was fit enough to join the forces.”<sup>341</sup> Beveridge, like Chadwick before him, recognised that a combination of the evils of poverty, poor sanitation, inadequate diet and disease, particularly tuberculosis were responsible.

Beveridge’s role and particularly his dedication to universalism, intended to include the elderly, is outlined by his main biographer as follows:

*“He saw the goals of administration as idealist goals – the enhancement of the powers of a beneficent state, the harnessing of feelings of social benevolence and the reconciliation of antagonistic social forces...He tended to perceive all social problems as administrative problems, believing that ‘all problems are soluble given enough staff...But as he later admitted it also misled him in attempting to impose administrative remedies on problems that were largely incapable of administrative solution – such as the economic problem of inadequate labour demand.”*<sup>342</sup>

The main agenda at the start was to achieve an appropriate financial agreement for taxation and also to provide a free at the point of delivery system of health care. In much of his work on welfare reform Beveridge was careful not to become too directly affiliated to any political party but operated in a pragmatic way, says Jose Harris and that he seems to ‘flirt’ with the Liberal party from time to time in these earlier and middle years of his career.

Interestingly, in terms of what was to come much later on, in 1924 he published a Liberal pamphlet “Insurance for All and Everything” and drafted a private members bill for the introduction of contributory old-age pensions and widows and orphans insurance which apparently temporarily became official party policy, but

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<sup>341</sup> Fraser, *Ibid*, p.195.

<sup>342</sup> Jose Harris, *Ibid*, p.215.

Beveridge shrank from further involvement when he witnessed the political infighting which followed in its wake. He regarded himself as the provider of an expert analyses rather than acting as a party politician.

The aim of social insurance was to provide a basic state pension. It was defined as follows:

*"...a logical development of the views which Beveridge had expressed seventeen years earlier, and an attempt to introduce into Britain a system of social insurance coverage even wider in scope than Bismarck. It was designed to reduce to a minimum the need for discretionary relief and to supersede the system of non-contributory old-age pensions which Beveridge in 1908 had denounced so strongly for penalising thrift."*<sup>343</sup>

It was not so easy to achieve. Beveridge's biographer notes that in July 1924 an official committee under Sir John Anderson reported unfavourably on "all-in" insurance and "in particular criticised Beveridge's scheme for exaggerating the yield of the unemployment fund by asserting that it would have a surplus which could fund other needs, ignoring the difficulties of insuring females, and generally underestimating the problems of administrative simplification."<sup>344</sup>

The following year, Neville Chamberlain presented a Bill to Parliament which became the Widows, Orphans and Old Age Contributory Pensions Act 1925.<sup>345</sup> This Act established a contributory pension scheme for 65-70 year olds and maintenance for widows. The Act fell short of Beveridge's concept of "all-in" insurance, but the

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<sup>343</sup> Jose Harris, *Ibid*, p.222.

<sup>344</sup> Jose Harris, *Ibid*, p.233.

<sup>345</sup> (15 & 16 Geo.5, c.70).



link of the new benefits to the existing national scheme of health insurance was well made which overall attracted Beveridge's approval.

The example of social security linked to pensions shows the complexity of reform and the difficulties of implementation. The achievement was due to Lloyd-George as a social reformer, and Chamberlain also used his ministerial office as Minister of Health in the 1920s and Chancellor of the Exchequer in the 1930s.

Significant also was the Local Government Act 1929<sup>346</sup> piloted through Parliament by Health Minister, Neville Chamberlain. The Act abolished poor law unions and transferred their public assistance responsibilities, at the heart of elderly care support, to the county council and county borough council local government structure, who were also thereby empowered<sup>347</sup> to take over poor law infirmaries as municipal hospitals, "Chamberlain hoping to thereby trigger a new national hospital service, but the take up by use of these powers was not at any impressive rate".<sup>348</sup>

The Royal Commission on Unemployment (1932-1934) effectively recommended that the whole unemployment issue be taken out of politics and inconsistent local control, resulting in the Unemployment Act 1934.<sup>349</sup> This established the Unemployment Assistance Board. However, the structures thereby put in place were very significant in terms of the Beveridge structures which were to follow.<sup>350</sup>

*"The 1934 Act had a profound effect upon the Poor Law, which lost almost all of its able-bodied adult males and became a generalised relief agency meeting a variety of residual conditions. The old 1834 Poor Law had virtually*

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<sup>346</sup> (19 & 20 Geo.5, c.17).

<sup>347</sup> But significantly not 'compelled'.

<sup>348</sup> Fraser, *Ibid*, p.225.

<sup>349</sup> (23 & 24 Geo.5, c.29).

<sup>350</sup> Particularly the National Assistance Board in 1948 with its far wider remit than unemployment.

*disappeared. In 1929 the guardians had been disbanded and the 1930 Poor Law had abolished the workhouse test and the term “pauper”...the Public Assistance Committees could...still remain an all-embracing, last-resort, general assistance service.”<sup>351</sup>*

Further reforms proved to be predicated by the outbreak of the Second World War. Fundamental economic, political and social change brought about by the onset of the Second World War in 1939 were to largely unify the nation against the common enemy and do much to accelerate the pathway to the 1942 Beveridge Report.<sup>352</sup>

It was Chamberlain’s Health Ministry, which in 1939 on the outbreak of war, organised the emergency medical services which included over two thirds of all British hospitals and which in turn included:

*“...prestigious voluntary hospitals and famous teaching hospitals. After 1939 both public and voluntary hospitals were to deal with two quite distinct categories of patients, those who were in the emergency services (primarily service personnel to start with), who received free treatment financed and organised on a national basis, and those who were not...The war-time government was forced to extend the emergency service little by little to patients other than service personnel...that by 1944 there were twenty-six main categories of patients eligible for the emergency medical service...It thereby promoted the case for a national state hospital service.”<sup>353</sup>*

Chamberlain’s resignation as Prime Minister made way for an All Party Coalition Government in May 1940, which included the trade unionist, Ernest Bevin, as

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<sup>351</sup> Fraser, *Ibid*, p.215.

<sup>352</sup> *Social Insurance and Allied Services* – Report by Sir William Beveridge (November 1942 – Cmd.6404).

<sup>353</sup> Fraser, *Ibid*, p.234.

Minister of Labour. By December 1940 Beveridge was appointed to an Under-Secretary position in that Ministry in charge of its military service department. His personality clashes with Bevin were extensive; “Ernest Bevin...was by now determined to remove Beveridge from the Ministry of Labour...”<sup>354</sup>

Later he was offered the job of chairman to an interdepartmental enquiry that was to be set up on co-ordination of social insurance. “The social insurance enquiry had initially been opposed by Bevin, but he changed his mind when he saw that it was a chance of ridding himself of Beveridge.”<sup>355</sup> According to Jose Harris, Beveridge was fully aware that he was being “kicked upstairs.” The formal appointment to this chairmanship in June 1941 was by Arthur Greenwood, Minister without Portfolio, in charge of reconstruction.<sup>356</sup>

The events leading up to reform and the creation of the NHS are worth explaining. Jose Harris states that:

*“...throughout the 1930’s there had been a growing body of criticism of the social welfare system – ... which Beveridge ... had shared. Rowntree’s study of York in 1936 found that, whereas thirty-seven years earlier poverty had been mainly caused by low earnings, it was now mainly due to unemployment and .. inadequate provision for...old age...;...This growing desire for some kind of major reform of the social welfare system was strongly reinforced by the outbreak of war.”*<sup>357</sup>

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<sup>354</sup> Jose Harris, *ibid*, p.242.

<sup>355</sup> Jose Harris, *Ibid*.

<sup>356</sup> Report of the appointment reproduced on P.2 of Cmd.6404 *Ibid*.

<sup>357</sup> Jose Harris, *Ibid*, p.244.

In particular perhaps Beveridge “had urged the need for ‘social reconstruction’; partly to give the British people something worth fighting for and partly to ease the eventual transition to peace.”<sup>358</sup>

Other influences included wartime bombing and evacuation, exposing the depth of urban poverty, and the fact that both the First World War and the Second World War had yielded an enormous expansion of state control, withdrawal of which after the First World War had given way to massive unemployment and economic depression.

Jose Harris mentions that other complexities were in attendance, including a deferred workmen’s compensation Royal Commission of 1938<sup>359</sup> and pressure upon the Ministry of Health to extend the scope of health insurance and sickness benefit. That ministry was also under instructions to start planning a major extension of medical services, but the officials considered that the latter could not be achieved in isolation from social security reform more generally, “since there is no problem of public health which does not have a common frontier with the treatment or rehabilitation side of social insurance.”<sup>360</sup>

Significantly, in March 1942 Beveridge consulted Maynard Keynes (1883 - 1946), then a senior Treasury adviser about financing the services he envisaged proposing in his report. Among other financial issues Keynes’ contribution was to urge Beveridge “to be very specific in his final report about the projected level of contributions and benefits...Keynes admitted that he was now converted to Beveridge’s plan for making pensions conditional on retirement...”<sup>361</sup>

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<sup>358</sup> Jose Harris, *Ibid*, p.245.

<sup>359</sup> Affected by wartime disruption in terms of its members being allocated other duties.

<sup>360</sup> Jose Harris, *Ibid*, p.247.

<sup>361</sup> Jose Harris, *Ibid*, p.247.

Keynes involvement at all was a coup on Beveridge's part, as Keynes, of Cambridge University, had established himself from the 1930's onward as a driver of economic thought engaging governments both nationally and internationally.

Harris also notes that evidence was taken from the TUC was influential. Originally the TUC had been reluctant to compromise on many issues ultimately agreed with Beveridge on every major issue – with the sole exception of workmen's compensation. Beveridge's "cordial relations with them [the TUC] at this time were a striking contrast to the...hostility that had existed between him and the trade union movement during the First World War."<sup>362</sup>

Keynes' contribution to the report as an economist of worldwide stature contributed much to the eventual report's parliamentary acceptance. Equally perhaps a Labour Government hand in hand with the TUC would find its path towards implementation by statute of such radical measures very much easier, carried upon a tide of popular approval.

Jose Harris acknowledges how Beveridge's deliberative strategy of interpreting the scope of his terms of reference in an extremely liberal way helped him to achieve what he hoped for. Fraser says "The Beveridge Report was...an immediate bestseller, with total sales of some 635,000. It was the culmination of a lifetime's influence upon social administration which had begun with Beveridge's advocacy of labour exchanges and insurance in 1909."<sup>363</sup>

The Report's dynamic effect in driving the political machine towards implementation was one of profound significance. A high profile civil servant of great organisational experience had used lengthy analysis and expert evidence to

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<sup>362</sup> Jose Harris, *Ibid*, p.248.

<sup>363</sup> Fraser, *Ibid*, p.235.

demonstrate to the population at large that the scheme, and a better post-war world, was completely achievable. Many war-weary civilians and members of the armed forces are shown to have clung to this 'dream' with immense tenacity, the post First World War social depravation and economic collapse being in the living memories of many people. The months and remaining years of war that followed the Report were to witness the enormous social and political momentum that politicians would ignore at their peril. Almost alone amongst these politicians perhaps was Winston Churchill, who despite his earlier years being engaged in progressive social policy change, appeared to have his focus solely on winning the war rather than on what lay beyond that objective.

That said about Churchill, the dynamism to which Churchill must have been a party is evident from three White Papers published in 1944 by the Coalition Government, the most significant and detailed of which was that of February published by the Minister of Health:<sup>364</sup> "A National Health Service." As a political document, it seriously developed and 'fleshed out' the broad Beveridge strategy. Its sheer detail is testimony to that. However, the White Paper was to use the "building blocks" of the Local Government Act 1929<sup>365</sup> thereby keeping municipal control over hospitals.<sup>366</sup> The very detailed structure proposed in this very large document included many aspects of planning and policy and also included a proposal for local authority control of voluntary hospitals.

It may be concluded that the period of enormous social change and its accompanying legislation from the legacy of Chadwick to the interactions of many others, but in particular Beveridge, a man in Chadwick's own template, has traversed

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<sup>364</sup> (Cmd. 6502).

<sup>365</sup> (19 & 20 Geo.5, c.17).

<sup>366</sup> In the event that was not proved to be the case, in 1948 as a result of the 1946 involvement of Nye Bevan.

a period in which there has been much social engineering, coupled with the Victorian development of state hospitals for the poor, the Royal Commission on the Aged Poor of 1893, the social change towards pensions and their enactment in the 1908 Act representing a huge milestone in state welfare progression have all been great developments for the elderly in particular.

In this process, Neville Chamberlain himself steers through Parliament the 1925 statutory extension of the 1908 Act,<sup>367</sup> as well as the Local Government Act 1929,<sup>368</sup> although the latter legislation had empowered local authorities to take over old poor law hospitals so that they could become municipal hospitals, the success of that process was observed by Fraser to have been “slow.”<sup>369</sup>

Again, it was Neville Chamberlain’s Health Ministry that in 1939 set up the emergency medical services, which took over two-thirds of the then British hospitals for the purposes of putting medical services on a war footing, and this process was to substantially “pave the way” for the NHS hospital system, as was the extension of state control itself for the purposes of the Second World War. Perhaps the ultimate master stroke of the 1942 Beveridge Report was to engage the support and input of John Maynard Keynes.<sup>370</sup>

This White Paper includes the founding principles of the NHS. It was to be funded out of general taxation and not through national insurance, and services

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<sup>367</sup> Widows, Orphans and Old Age Contributory Pensions Act 1925, 15 and 16 Geo.5, c.70.

<sup>368</sup> (19 & 20 Geo.5, c.17).

<sup>369</sup> Fraser, *Ibid*, p.235. This system was criticised for its lack of success on 5 October 1945 by Aneurin Bevan, the then Health Minister – Nye Bevan, Cabinet Memorandum 5 October 1945 – [www.nhshistory.net/bevancab.htm](http://www.nhshistory.net/bevancab.htm).

<sup>370</sup> Beveridge having remembered well presumably the criticism of the Anderson Committee of July 1924 in respect of another project of Beveridge’s at that time, the criticism being that “Beveridge had a capacity of underestimating problems by administrative simplification”. Keynes became an internationally renowned economist in the inter war years and as a result of his main publication in 1936 he had “secured his position as Britain’s most influential economist, and with the advent of World War II he again worked for the Treasury. In 1942 he was made a member of the House of Lords.” – [www.bbc.co.uk/history/historic\\_figures/Keynes\\_John\\_Maynard.shtml](http://www.bbc.co.uk/history/historic_figures/Keynes_John_Maynard.shtml).

would be provided by the same doctors and same hospitals but services were provided free at the point of use, financed from central taxation, and everybody was eligible, even those visiting the country. Universalism as it became known was established as a mechanism for state delivered health care including the elderly.

#### 4.2 The National Health Service Act 1946 and the National Assistance Act 1948

Post war Britain and the immediate defeat of Winston Churchill,<sup>371</sup> the war-time Prime Minister, created a major change to the role of the state. The Beveridge Report was part of a long list of historic influences with social reformers Bentham, Chadwick, Lloyd-George, and Chamberlain.

The Beveridge reforms needed implementation and in the Government of the day it fell to Nye Bevan as minister of health to take matters further forward. One sharp divergence between the Government and the White paper of 1944 setting out the reforms emerged. Bevan and his Cabinet preferred a centralised focus rather than full local government control of health care services.<sup>372</sup>

This shift in policy was about funding logistics and control. Funding involved large sums of public money that enjoyed central government control and this could not be easily conceded to local government. Bevan's detailed reasoning is clear in his Memorandum to the Cabinet of 5 October 1945,<sup>373</sup> and arose directly from the lack of success of municipal hospitals generally (with a few exceptions) after the 1929 Local Government Act and specifically on the question of finance. On that

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<sup>371</sup> In the General Election of 5 July 1945.

<sup>372</sup> Which to this day that issue lies at the heart of fierce debates about the lack of "joined up" healthcare delivery, particularly to the elderly.

<sup>373</sup> Cabinet Memorandum 5 October 1945 *Ibid.*



issue, it was strongly urged by Bevan on his fellow Cabinet Ministers to pursue a centrally funded hospital system with Central Government Control, as follows:

*“A few local authorities run a good hospital system. The great majority are not suited to run a hospital service at all under modern conditions. Areas are usually too small for the needs of the specialised services; the present artificial demarcation of town and country in local government is inconsistent with the right arrangement of hospital responsibilities; the ordinary local authority cannot attract and maintain the quality of expert officers needed for organising modern specialist services; the costs of up-to-date hospital and specialist facilities cannot properly be thrown on local rates without heavy Exchequer subsidy and in any case would not fall equitably (except with a great deal of juggling) upon the present variety of rating areas which a big hospital service must serve. Local government, as we know it, is already overloaded – and a new nation-wide hospital and consultant service is too big and unsuitable a burden to put upon it.”<sup>374</sup>*

This was an important policy decision and its significance has continued to gain importance for the remainder of the 20<sup>th</sup> century and into the 21<sup>st</sup> century.

The 1946 National Health Service Act,<sup>375</sup> contained a comprehensive health universalism including its elderly care components, and the Act came into force on 5 July 1948. Perhaps surprisingly was some serious opposition to the Government which came from the medical profession, who complained about lack of independence and feared state control. In fact it was a fear of losing relations between doctor and patient to the state. This led to an apparent ‘impasse’ facing the

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<sup>374</sup> *Ibid.*

<sup>375</sup> (9 & 10 Geo.6, c.81). (itself repealed by the National Health Service Act 1977 [1977, c.49]).

implementation of the 1946 Act was gradually overcome by lengthy and difficult negotiations and many political concessions.

Firstly the consultant medical profession was gradually won over via the Royal College of Surgeons and the Royal College of Physicians amid concessions that they could continue their private work alongside their contracted NHS practising, meeting their objection of being compelled to become mere servants of the State. Then the general practitioners were eventually won over with similar contractual concessions.<sup>376</sup>

Perhaps overlooked in the debate within the medical profession and the Government over the role of the new National Health Service was the plight of the elderly. Poverty and illness seemed to afflict many. Most of the 4.6 million aged 65 and over, which included 1.5 million aged 75 and over, in 1948 had experienced deprivation, inferior housing, and a primitive level of health care. Many of these had been exposed to occupational hazards and war invalidity.<sup>377</sup>

One example is illustrative of the problem. Poor eye sight and hearing was often unaided. Many elderly became deaf without access to hearing aids, lost mobility without expecting remedial help, used the pharmacist as their doctor for moderate ailments and faced with stoic courage the financial challenge of having to consult a medical doctor in an overcrowded surgery. Any necessary consignment to the existing chronic and infectious disease hospital system or sanatoria was a degrading experience, but for the elderly associations prevailed of the stigma of Poor Law charity.<sup>378</sup>

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<sup>376</sup> But they in particular showed a strength of unity and cultural resistance to change which every government since has experienced via their strong union the BMA.

<sup>377</sup> Charles Webster, chapter in collected essays - *Life, Death, and the Elderly*, Eds. M. Pelling and R. Smith Routledge (London and New York: Routledge, 1991), 167.

<sup>378</sup> Charles Webster – *ibid* – Page 168.

Demand, mostly by the elderly, in the first nine months of the NHS for sight tests and spectacles, dental treatments and supply of dentures, and unrestricted access to modern drugs, in huge volume terms took the government by surprise.<sup>379</sup> Also, a vast improvement was experienced by the elderly requiring and receiving acute care at NHS hospitals.

The philosophy of community care built into the legislative changes was however less successful in terms of elderly people and chronic illnesses, where unintended lengths of stay on wards became a matter of continuing concern. In some cases conditions had been untreated for too long without specialist care, but generally across the spectrum of growth of elderly long-stay patients bed blocking issues arose in conjunction with slow growth of rehabilitation facilities.

The above chronic care issues have persisted into modern times, but in the earlier years of the NHS it was relatively soon officially realised that Poor Law hospitals were largely incapable of adaptation to modern requirements.<sup>380</sup> In the early NHS hospital system years therefore, and for many years since that recognition, the sheer financial challenge of gradually building replacement hospital facilities has been very substantial, resulting largely in the NHS failing to bring about a revolution in chronic elderly hospital care.

The health reforms exposed a largely unmet need of neglect, inertia and ignorance about the plight of many elderly patients too poor to see a doctor or receive medical attention...<sup>381</sup> Indeed how to optimise the new health service took a

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<sup>379</sup> Webster, statistical research, *Ibid*, p. 179.

<sup>380</sup> C.A. Boucher, *Survey of Services available to the Chronic Sick and Elderly - 1954-1955* (London: Ministry of Health- Reports on Public Health and Medical Subjects, No.98, HMSO, 1957).

<sup>381</sup> P. Townsend, *The Last Refuge, A Survey of Residential Institutions and Homes for the Aged in England and Wales* (London: Routledge & Kegan Paul, 1962) – noting that by 1962 successive governments since the war had made no serious attempt to collect the necessary information or to review developments in policy- Page 21.

long time to establish. There was some official reluctance to promote its cause and often inaction in identifying special categories of need. Some officials may have assumed that the elderly were being generously treated with pensions and support. Some may have believed that support to the elderly was over-generously treated on the pensions front already, and the NHS was a profligate experiment.<sup>382</sup>

#### 4.3 Local Government

Some mention should be made of the important role of local government after the Beveridge reforms were introduced. The National Health Service Act 1946 required local government to establish Local Health Authorities (LHA's) to carry out the health centre programme, which itself was expected to play a crucial part in the development of services for the elderly. LHA's were also given a statutory responsibility to provide a health visitor and home nursing service, and enabled to make arrangements for preventive measures, care and after-care services, and home helps. This provided an important range of social and health services, while leaving the main responsibility to central government.

In implementation terms it seems that the first few decades of local authority health visitor activity were preoccupied with maternity and child welfare rather than elderly care delivery, but by 1960 the elderly were known to form a growing percentage of that activity, by which time the bedridden elderly were in grateful receipt of laundry services.<sup>383</sup>

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<sup>382</sup> Webster, *Ibid*, p. 175.

<sup>383</sup> Webster, *Ibid*, pp. 183 – 185.

These July 1948 innovations are historically incomplete without analysis of the enacting of the ‘sister’ legislation, the National Assistance Act 1948.<sup>384</sup> Although receiving the Royal Assent on 13 May 1948, its timing for implementation on 5 July 1948<sup>385</sup> with the National Health Service Act was well co-ordinated.

Elderly care is mentioned as the 1948 Act that had formally repealed and replaced the poor law, but set out the terms of the new reform:

*“An Act to terminate the existing law and to provide in lieu thereof for the assistance of persons in need by the National Assistance Board and by local authorities; to make further provision for the welfare of disabled, sick, aged and other persons and for regulating homes for disabled and aged persons and charities for disabled persons.”*

This came into statutory effect as a state funded ‘safety net’ to support any person in need, as well as the elderly who still rely on part of the Act still in force now being Section 21(1)(a) which provides that “a local authority may with the approval of the Secretary of State, and to such extent as he may direct shall make arrangements for providing residential accommodation for persons aged eighteen or over who by reason of age, illness, disability or other circumstances are in need of care and attention which is not otherwise available to them.”

The continuing effect in conjunction with this provision of Section 26 which provides “...arrangements under section 21 of this Act may include arrangements made with a voluntary organisation<sup>386</sup> managing any premises.”<sup>387</sup>

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<sup>384</sup> (11 & 12 Geo.6, c.29).

<sup>385</sup> National Assistance Act 1946 (Appointed Day) Order 1948 (1948 No.1218) (signed by Aneurin Bevan as Health Minister).

<sup>386</sup> For example, a charity such as the Leonard Cheshire Foundation primarily focussed on the elderly.

<sup>387</sup> Thus private contractual provision for profit was significantly not permitted until this section was amended to that effect by Section 26 of the National Health Service and Community Care Act 1990 (1990, c.19) brought about by need, and from which point private provision for profit then developed triggering many other issues.

Central government's role in long-term care was narrowly defined to finance disability benefits and through grants and aid in the 1980s to reimburse care homes for the board and care of the elderly frail in private care homes. Local government greatly expanded its provision for social services for the elderly and this became one of its largest sectors of activities as social service departments expanded to meet the demand and deliver elderly care services. State provision rapidly gained acceptance and recognition. There were restraints on funding. Local government soon realised that it had to act cautiously as it did not want to put at risk acute hospital beds for the elderly with no choice in the matter. There was no uniform set of delivery targets and in many cases different local authorities would fund what other local authorities expected to be charged to the patient. In many ways the rise of a private sector for elderly care was seen as a welcome development that took away costs and expenses from local authorities<sup>388</sup>.

Commercial sector involvement in care homes was remarkably limited throughout the 1960s and 1970s. This was soon to change after November 1980, when social assistance schemes reimbursed private homes for the care of the elderly and frail. This was to have a transformative impact on care delivery for the elderly.

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<sup>388</sup> An authoritative report in 2010 describes a remarkably parallel French care delivery system for Long Term Care (LTC), said to be philosophically modelled on a mixture of Bismarck and Beveridge and its family and neighbour participation, whereby since the 1980's central government as policy setters incentivised local government at Department level (les Conseils generaux) to engage in care delivery, and its challenging complexities. "Departmental authorities readily accepted this new responsibility....satisfying increasing demand, but also a big opportunity in terms of employment." Since 2004 legal changes local departmental authorities are considered as 'leaders' in the field of dependency, and define policy for disabled elderly people, "planning and co-ordination, and financing a major part of the personalised autonomy allowance (APA)".S Departments grant approval for care services and even set care home fee levels, with general but mixed levels of success across the 96 mainland France structure of Departments. Joined-up care delivery issues and even how to define "care" also trouble the French:- European Network of Economic Policy Research Institutes (ENEPRI) – *Long Term Care in France* (Report No.77 -June 2010)- Marie-Eve Joel and others- Pages 1 to 9.

#### 4.4 Conclusions

The birth of the welfare state was clearly a complicated and time-consuming process. The 1908 pension provision was a major landmark decision. This recognised the elderly in a way that proved significant.<sup>389</sup> The Beveridge reforms brought elderly patients into medical treatment often for the first time.

However, whilst the Beveridge Report is clearly fundamental to the creation and subsequent development of the welfare state, embracing Beveridge's universalism philosophy it is notable that elderly care does not come high up the agenda, although medical care of the elderly does. In its first couple of decades from 1948 amongst the shortcomings in the new welfare state is a connection between the elderly not being regarded as a priority by senior Ministry of Health civil servants and the issue of incomplete universalism.

The post-1948 NHS brought to the elderly the availability of hospital consultants, desperately needed free dentistry hearing aids and spectacles, and then general practitioners (GP's), but domiciliary care services were slow to catch up and because of the inferior status of the elderly in the eyes of many services for the elderly were always disproportionately affected by charges and cuts. These cover the medical treatment for dementia in its various forms, other mental health disorders, convalescent and respite care, frail disabled care, palliative/end of life care and residential care.

One significant post 1948 NHS hospital improvement was that the presence of many elderly in hospitals triggered the growth in a specialist geriatric

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<sup>389</sup> For example the Chronically Sick and Disabled Persons Act 1970 (1970, c.44).

profession.<sup>390</sup> Hospital modernisation programme, and a framework domiciliary care delivery system were also undertaken but this was patchy as resources were limited. Resources continued to pour into inefficient long term hospital, and even new care home construction, in each using models, often repeated the defects of old workhouses. Always present were the complexities of continued finance along with continuing increases in elderly longevity.

The growth in the state's provision for health care had implications for the charitable sector. Voluntary action was to be encouraged as part of health care delivery and the Charity Commission received continued government support. Elderly care continued to be delivered by families and charitable/ religious organisations that contributed to the general well-being of many elderly patients. Health care visitors and supportive nursing and palliative care provided an important support – bridging different elements of the public and private sectors.

As we have seen local government was given important responsibilities for the elderly notwithstanding the creation of a nationalised health service. These included residential and domiciliary care. This made local government a pivotal part of elderly care through home care provision or also enabling local authorities to establish and run care homes and play by far the major role across various elderly care delivery services.

This was a defining period for elderly care and by 1968 local government was given a general power to promote the welfare of the elderly. A large proportion of elderly lived in their own homes supported by their families but also supported through home care systems. Local authority delivery of elderly care services reached

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<sup>390</sup> [www.nhs.uk/history](http://www.nhs.uk/history).



a peak in the 1980s. It was set to change with the private sector market developing a market in private care homes.

## CHAPTER 5: Elderly Care, the National Health Service 1948 to the Community Care Act 1990

### 5.0 Introduction

The period after the nationalisation of health care may be considered as an important transitional stage in the evolution of elderly care. Local government progressively received competencies to deliver social services for the elderly, but central government regulated finance and administered social assistance. Limitations in terms of budgets and the complexity of applying and receiving funding added to the difficulties of delivery.

From the advent of the National Assistance Act 1948 there grew a system of local care homes were primarily local authority or voluntary sector run and owned, with limited private or commercial ownership. Under that Act these were providing accommodation for the elderly and others “in need of care and attention which is not otherwise available to them”, but not the sick elderly for whom the NHS was responsible.

Initially modest numbers of elderly people were relatively easily accommodated by the local authority care home system, together with the elderly and others who could be charged for accommodation.

The immediate post-war situation in terms of government already launching the 1948 welfare state with its centralisation of former local authority functions such as district nurses and some health services, was also nationalising railways, coal mining, steel and utilities industries, some of the latter having been local authority controlled. The cost was well beyond a bankrupt nation's means, but this enormous

centralisation process was going to leave a couple of decades before elderly people even became a meaningful statistic so as to engage political policy attention.

Thereafter there was largely progressive political policy recognition that local government had a constructive role to play in the delivery of elderly care services with the increasing complexities those were taking on.

In the 1970's the elderly received significant recognition in health policy documents that focused specifically on their needs. It is estimated that between 1979 and 1989 publicly funded residential care increased in England and Wales "from expenditure of several million pounds to over £1billion in expenditure."<sup>391</sup> The emergence of state payments of personal income support as an open ended source of funding for care homes at the very end of the 1970's fuelled massive growth in care home capacity in response to growing demand from an ageing population.

One of the most significant changes was the introduction in the late 1980s of the NHS and Community Care Act 1990. This marked a dramatic change in policy. Local authorities were in control but state social security payments were used to facilitate to pay for care homes. As the Joseph Rowntree Report noted:

*In time this policy resulted in a consolidation of residential bed provision and a gradual focus on the development of better community care alternatives, although with a continuing concern that all social care was difficult to access and fund. The result was that many families and partners continued to provide informal care that was often unsupported by the State.*<sup>392</sup>

Since then, and with the growth of private care home and voluntary services, and some domiciliary service extension, services for the elderly have improved in some

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<sup>391</sup> Laura Banks, Philip Haynes, Susan Balloch, and Michael Hill, *Changes in communal provision for adult social care 1991-2001* (Joseph Rowntree Foundation (JRF), 2006), p. 2.

<sup>392</sup> JRF (2006), *Ibid*, p.2.

respects, but the scale of response has been inadequate to the magnitude of the problem with some of the social services used by the elderly having been prime targets for cuts in health service expenditure.

Care home provision reached a peak in 1996 with over 575,000 places but the market in care homes has changed. Smaller homes closed; larger care homes became the new norm and a developing private sector of care home provision has developed. In 1998, the new Labour Government introduced attempts to Modernise Social Services. Funding has always been problematic.

Local authorities had to act cautiously. Elderly care was linked to health care provided by the National Health Service. Various geriatric provisions were fully funded by the health service and not directly under local authority budgets. One major concern was that if local authorities were to increase their share of the provision of elderly care, then NHS providers would pass on the costs to local authorities.

## 5.1 State and private provision of elderly care - setting the framework after Beveridge

There is the general acceptance that the National Assistance Act 1948 had brought about reform of public assistance institutions by replacing them with local authority residential homes, but the Act did not empower development of general welfare support of older people who remained in their own homes. This absence is a recurring feature of the British system where the social security system often did not address the main providers of elderly care namely families and their friends. However, the 1948 Local Government Act<sup>393</sup> empowered<sup>394</sup> grants by them to

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<sup>393</sup> (11&12 Geo.6, c.26).

<sup>394</sup> But did not compel.

voluntary organisations to develop general welfare services, such as ‘meals on wheels’ for the elderly.

The 1948 legislation did not really progress until the National Assistance (Amendment) Act 1962 prescribed that local authorities could directly provide meals services because demonstrably the voluntary sector had not been able to develop national coverage to meet obvious growing need. Even so it took the Health Services and Public Health Act 1968<sup>395</sup> to make discretionary home help services mandatory.

Implementation of policy change by central government over the last quarter of the 20<sup>th</sup> century shows increasing local authority engagement, increasing private and diminishing public care delivery. Provider competition, rationing, targeting and the economic necessity of less local authority direct care home provision become the watchwords. By the last decade of that century, national policy has also driven a visible change in the increasing number of elderly being maintained for longer in their own homes or with families<sup>396</sup>.

One clear message from the above implementation level of local government officials involvement is from the 1970’s central government gradually engages with elderly care issues along with substantial regulatory change with the Registered Homes Act 1984 and eventual policy realisation that modern equipment has greatly improved to facilitate the delay or prevention of care home use for the elderly. This

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<sup>395</sup> Even implementation of the 1968 Act on this fell foul of concurrent local government social services re-organisation implemented on 1 April 1971 because of the merger of local authority welfare departments with the functions of others. Radical local government upheaval on 1 April 1974 (pursuant to the Local Government Act 1972 {1972, c.70} implementing a previous Royal Commission), soon added to the administrative confusion. In each of the changes interim preparation and transitional arrangements confused officials and the public.

<sup>396</sup> Robin Means, Hazel Morbey and Randall Smith, *From Community Care to Market Care? – The development of welfare services for older people* (Bristol: The Policy Press, 2002).

modernisation includes better mobility machinery and local authority funding of the elderly person's home adaptation.

In its continuing empirical analyses detail the same 2002 Study<sup>397</sup> shows progression by the late 1980s for home care staff to extend their skills set by being encouraged to take on a growing amount of personal care tasks, a momentum which continues thereafter clearly aiding reduction of care home use.

Nevertheless, with local authority homes, "...the late 1970's and early 1980's was also a period of neglect for such homes in terms of physical standards and often in terms of quality of care. These deficiencies were exposed by the rapid development of independent sector residential and nursing home care in the 1980's and the associated passing of the 1984 Registered Homes Act."<sup>398</sup>

The 1984 Act recognised the need to structure a growing private sector of accommodation which paralleled an existing nursing home system,<sup>399</sup> where the boundaries between the two were not always clear and required regulatory oversight.<sup>400</sup> Private home expansion was itself stimulated by local authority home closures rather than such authorities trying to financially resource facility upgrades in times of great budgetary constraint as well as demographic influences.

Specifically the Law Commission in 1983 had been requested to examine and report back to the Lord Chancellor the Government's stated purpose to continue to assimilate legislation relating to residential care homes and the then legislation relating to nursing homes, respectively then the Health and Social Services and

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<sup>397</sup> Means and Others, *Ibid*.

<sup>398</sup> (1984, c.23) – *Means and Others Ibid*. p.69.

<sup>399</sup> Repealed by the Blair Labour government's Care Standards Act 2000 (2000, c.14) which replaced the 1984 Act standards with more stringent levels of regulation again (38 standards were enumerated) overseen by the new Commission for Social Care Inspection.

<sup>400</sup> Implementing in this respect Law Commission Report LC 128 (December 1983)- specifically reporting to Parliament on the Registered Homes Bill 1983(Cmnd.9115).

Social Security Adjudications Act 1983<sup>401</sup> and the Nursing Homes Act 1975,<sup>402</sup> in respect of which the proposed consolidating statute under consideration had raised technical inconsistencies in respect of secondary legislation and criminal offences in the intended combined regulatory oversight.<sup>403</sup>

The new statute provided for compulsory registration, standards and inspection of residential care homes as a new category<sup>404</sup> a similar structure for nursing homes,<sup>405</sup> and a registered homes tribunal system with its structure and jurisdiction.<sup>406</sup> The effect appears to have been to increasingly drive up the cost of compliance by care providers as well as standards but, in respect of the latter, the consumers were increasingly expectant of rising standards.

Also in focus in the study<sup>407</sup> of the local government officers are issues affecting elderly care delivery identifying the then continuing tensions between local authorities and their NHS local counterparts, particularly cultural issues, when common funding arrangements are redirected by Government as political experiments, or provided on a finite basis, and also in particular in respect of older people with dementia. Although defined as an organic illness “there is often little medical intervention available or appropriate and so their greatest need is for social support. A consequence of this in the study period was growing numbers of older people in local authority residential care.”<sup>408</sup>

The more notable conclusions of the study are that a comprehensive policy direction appears to have been achieved, but “there is no consolidated legal

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<sup>401</sup> (1983, c.41).

<sup>402</sup> (1975, c.37).

<sup>403</sup> Resolved in the Appendix to the Law Commission Report – (December 1983) – *ibid*.

<sup>404</sup> *Ibid*. Part One, ss1-14, with appeals under s.15.

<sup>405</sup> *Ibid*. Part Two, ss21-33, with appeals under s.34.

<sup>406</sup> *Ibid*. S.39.

<sup>407</sup> *Means and Others* (April 2002), *Ibid*.

<sup>408</sup> *Means and Others* (study period 1973-2001), *Ibid*, p.90.

framework relating to services for older people equivalent to the 1989 Children Act.”<sup>409</sup> And even “if one argues that the financial investment in intermediate care is impressive, it would seem that the...dominant political concern is not the quality of life of older people but rather bed blockage.”<sup>410</sup>

A further valuable insight into the shift by local authorities in the late 1980s and early 1990s from running their own residential care facilities is the development of residential care schemes with the ‘not for profit’ voluntary organisation sector, especially housing associations. This appeared to be more politically acceptable than a council closing down homes as such, but some such schemes “...foundered on the problem of the size of the capital investment required to bring them up to registration standard.”<sup>411</sup>

Thus the foregoing analysis forms a picture of reactive progression from the post-war Beveridge welfare state into the 1980’s and 1990’s world of public and private mixes of care delivery but continuing the flawed lack of integration.

Parallel developments on the regulatory side of events track the course of legislation from nursing home specific regulation, notably the Nursing Homes Act 1975,<sup>412</sup> dealing with specialised delivery of professional nursing care organisations and local NHS oversight of these, to the joining together in one regulatory statute of that system and the residential care home system with the Registered Homes Act 1984,<sup>413</sup> representing significant regulatory progression.

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<sup>409</sup> (1989, c.41).

<sup>410</sup> Means and Others, *Ibid*, p.163-165. ‘Bed blockage’ referring to a problem still much in the news of older people overstaying in NHS hospitals thus preventing availability of beds to other patients.

<sup>411</sup> Means and Others, *Ibid*, p.111.

<sup>412</sup> (1975, C.37).

<sup>413</sup> (1984, c.23).



## 5.2 Benefits for the elderly and frail since the 1990s

Until the 1990s, the NHS tended to be paternalistic with limited choice for patients, but broadly representing the Beveridge universalistic model of healthcare delivery at the point of need.

Michael Hill, a social policy academic, has estimated “...that from 1979 to 1988 social assistance spending on people in independent care homes rose from less than £20 million to £850 million.”<sup>414</sup> Investing heavily in this sector incentivised the development of different strategies for the delivery of elderly care.

By 1993, when income support expenditure had spiralled out of control, the Government responded by giving budgetary responsibility for adult social care to budget-capped local authorities, and terminating open-ended income support funding to new claimants,<sup>415</sup> leading to a decline in demand, despite continued demographic ageing of the population.

There were also changes in the role of local government by the Local Government Act 1999.<sup>416</sup> This implemented a Government policy proposal the previous year, on the part of the new Labour Government elected in 1997, to change the system whereby local government deals with the performance of its purchase of services and goods and other functions.

In Part One of the Act, which was one of the primary changes, local government of England and Wales was given a new duty by statute to arrange for the achievement of ‘best value’ in the performance of their functions, and in particular, with the elderly, in relation to the purchase of goods and services by

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<sup>414</sup>Michael Hill, *Towards marketization and centralisation? The changing role of local government in long term care in England, France, Germany and Italy with Frank Boner and Anna Marazanati* (Cheltenham, 2010), p. 101.

<sup>415</sup> When the National Health Service and Community Care Act 1990 (1990, c.19) was implemented in that respect.

<sup>416</sup> (1999, c.27).

competitive tender. In addition, there were quite detailed regulatory provisions relating to audit of best value performance plans,<sup>417</sup> and for intervention and inspections in certain circumstances.<sup>418</sup>

Since the millennium the private and voluntary care home sector has looked like:<sup>419</sup>

*Top six care homes in the UK, April 2006*

Organisation	Homes	Beds	Market Share	Type
Southern Cross Healthcare	527	27,744	8.1%	Private
Bupa Care Homes	294	21,036	6.2%	Private
Four Seasons (JDM)	316	16,416	4.8%	Private
Barchester Healthcare	156	10,021	2.9%	Private
Anchor Trust	97	4,286	1.3%	Voluntary
Order of St John Care Trust	74	3,216	0.9%	Voluntary

Although by 1995 the care home sector had doubled in size compared with 1975, the mainly for profit independent sector emerged as having replaced the NHS and local authorities public sector as the principal source of care home supply. Also, significantly, 1996 was the year all care home places peaked in numerical terms, and there has been a steady decline from that peak each year since.<sup>420</sup>

There has also been a decline in the number of residential care homes, aided to some degree by implementation of more stringent standards of facilities and equipment in 2000,<sup>421</sup> bringing about the closure of a number of, mainly smaller, homes that were too expensive to adapt.

<sup>417</sup> *Ibid*, 1999 Act – Sections 7 – 9. Section 7 compelled the local authority annually to instruct its auditor to check for compliance; section 9 compelled publication of non-compliance if sufficiently serious.

<sup>418</sup> *Ibid*, 1999 Act – Sections 10 – 15. Section 10 itself gave the Audit Commission power to inspect and intervene if necessary where sufficiently serious.

<sup>419</sup> Terry Philpot, *Residential Care: A positive future* (Surrey: Residential Forum, 2008).

<sup>420</sup> Historic patterns and data analysis supplied in- *Strategic Commissioning of Long Term Care for Older People-* (September 2014) Laing & Buisson White Paper- Pages 8 and 9.

<sup>421</sup> By the Care Standards Act 2000 (2000, c.14) which set out 38 standards to be achieved including EU ones.

This has been part of a general trend towards larger care homes owned by corporate entities such as Barchester Healthcare, Four Seasons and Bupa Care Homes, together with voluntary sector major providers like Anchor Trust and Order of St John Care Trust rather than individuals or families. This 'enlargement' trend includes the remaining local authority homes. Nevertheless, the smaller private limited company has been and remains at the heart of care home provision.<sup>422</sup>

Care being dispensed to the elderly in the NHS and private hospital systems in England and Wales broadly divides into acute and chronic categories, with some elderly people requiring both types, and the transition of those patients to and from the nursing home and care home system is a frequent every day event such as with residents suffering heart attacks or fractures from falls being transported to hospitals and often back again. Families are frequently at the centre of these events<sup>423</sup>.

At the nursing or care home part of this system broad categories of resident divide between those requiring dementia or other mental disorder care, convalescent or other intermediate care, respite or holiday relief care, palliative/end of life care, young physically disabled care, learning difficulties care, frail disabled elderly care and elderly care for residents with no specific health condition. Residents frequently have more than one of these conditions, thus making the care requirements more complex on an individual by individual care delivery basis.

Typically care and nursing homes may have two thirds of residents suffering dementia or other neurological conditions such as stroke, depression, epilepsy or Parkinsons Disease, representing perhaps the reasons for their admission initially, or

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<sup>422</sup> *The Role of Private Equity in UK Health & Care Services- (May 2012) Laing & Buisson- Pages 11-14 and 27-28.*

<sup>422</sup> *Persistent challenges to providing quality care- an RCN report on the views and experiences of frontline nursing staff in care homes in England – (20 March 2012) – Royal College of Nursing – Executive Summary.*

admission for non-mental issues, unless such a condition develops later, is usually for heart disease, arthritis, diabetes and endocrine, fractures, osteoporosis, lung and chest disease or cancer being in descending order of some average data<sup>424</sup>.

Further health issues adding to the care complexity are common ones such as urinary or bowel incontinence, or both, persons 'exhibiting challenging behaviour, etc. Whilst clinical conditions such as described is the primary reason for home admittance, frailty is often the second, followed by housing problems.

In terms of trends care homes are moving away from being an alternative form of housing for frail older people towards a location of last resort for individuals with high support needs towards the end of life, and the distinction between "residential care" and "nursing care" is becoming increasingly difficult to make.<sup>425</sup>

Bupa Care Homes, together with Four Seasons, Barchester Healthcare and HC-One currently head the list of the largest UK providers in the 'for profit' private provider market, and the larger voluntary sector bodies are Anchor Trust, Order of St John Care Trust and Methodist Homes amongst many others. The vast majority, however, are run by smaller private limited companies, partnerships with or without limited liability, and individuals running several or even individual homes with or without nursing.

Since the financial crisis many have financially failed across the country<sup>426</sup>, and the lack of information transparency for people or their families making perhaps

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<sup>424</sup> *The State of Health Care and Adult Social Care in England – 2013/14* (16 October 2014) Care Quality Commission- HC691 –Pages 4-7.

<sup>425</sup> Data and analysis from- *The changing role of care homes* (January 2011)- N.Lievesley, G.Crosby and C.Bowman – Report for British United Provident Association (BUPA) and the Centre for Policy on Ageing (CPA) relating to BUPA care homes, one of the largest UK nursing and care home providers, with an average split between 73% of its residents receiving nursing care and the remainder residential care.

<sup>426</sup> Company Watch, describing themselves as a specialist financial risk management body reported on 24 October 2014 that "the care home sector remained mired in debt and financially distressed, "including 1,659

the biggest decision of their life to move into a home is a current major source of dissatisfaction as financial information disclosure is poorly regulated.

Most contemporary incorporated bodies of any description, including a number of charities or other voluntary bodies, delivering elderly care are private limited companies who, in terms even of historic and outdated financial information provision, are exempt under the Companies Act 2006 from compiling and filing publically accessible accounts if having an annual turnover of up to £5.6 million.<sup>427</sup>

This deficiency is not fully addressed by new provisions as to ‘market oversight’ by the Care Quality Commission under the Care Act 2014.

Notable amongst the major care home providers becoming insolvent in recent times was the Southern Cross Healthcare group which failed as a result of financially restructuring during the first decade after the Millennium with an unsustainable sale and leaseback rental structure. Much disruption for residents, their families and regulators followed.

Within this overall system of care provision two thirds of the recipients of care have local authority financial support for the continuing maintenance of their care home place, and the remaining third are broadly ‘self-funded.’<sup>428</sup> Today officials of local authorities are under pressure to hold down levels of fees paid<sup>429</sup> and have strong market control without any understanding of the pressures on private sector

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UK care home companies- around 30% of care home operators are in the Company Watch Warning Area(the average for the whole economy is 25%)”- [www.companywatch.net](http://www.companywatch.net).

<sup>427</sup> Companies Act 2006 (2006, c.46) – Section 383(4) – supporting the widely perceived view of a deficit in publically available financial information on most incorporated care home operators except the very largest, some of whom file Companies Act 2006 accounts at Companies House or Charities Act accounts with the Charities Commission – *Strategic Commissioning of Long Term Care for Older People – can we get more for less?* (September 2004) – Laing & Buisson White Paper – William Laing, a care home market oversight specialist – Page 18.

<sup>428</sup> Which term may include those supporting themselves from the sale proceeds of their own house, those financially supported or partially supported by their families, etc.

<sup>429</sup> Triggering cross-subsidy, where available to the provider, of ‘self-funders’ against the publicly funded elderly –Laing & Buisson White Paper-*ibid*-Page 5.

providers to fund the home based on commercial percentages for returns on their capital.<sup>430</sup>

This current perspective requires completion of other parts of the overall picture, particularly direct NHS state provision in the elderly care sphere. A large increase in the number and proportion of care home nursing places since the late 1980's together with increased medicalisation of care home care for non-nursing places has been matched by a large decline in available NHS hospital beds of all categories, except day beds.<sup>431</sup> Against this overall backdrop geriatric bed occupancy rates continue to maintain levels of around 90% to 95% across the NHS in England, being more chronic than acute patients.

A typical large care home operator in contemporary times has 75% of its residents having neurological or mental disorders, which subdivides into 44% of those having dementia, 20% as had a stroke, 20% with depression, 6% with epilepsy, and 5% with Parkinson's disease. In terms of non-neurological/mental conditions, the respective percentages are 21% with heart disease, 18% with arthritis, 14% with diabetes, 12% with fractures, 9% with osteoporosis, 8% with lung or chest disease and 7% with cancer.<sup>432</sup>

Current data analysis available makes it clear that individual residents often have more than one of those health conditions, and the information is self-explanatory as to the complexities of the variation of the care needs from one individual to the next, including some individuals who experience healthy ageing.

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<sup>430</sup> Considered by Laing & Buisson, *Ibid*, to be fair at 12% but by some local authorities to be fair at 6% - Page 16.

<sup>431</sup> Analyses set out in *The Changing Role of Care Homes* (January 2011) Nat Lievesley and Gillian Crosby for the British United Provident Association (BUPA) and the Centre for Policy on Ageing (CPA) – Page 15.

<sup>432</sup> BUPA and CPA Paper (January 2011), *Ibid*, p. 1 (summary :- in respect of BUPA UK care homes one of the UK's largest care home providers).

Care in this context is at its most non-generic meaning, and means far more than good equipment and facilities. Currently the desirability of well trained and dedicated long serving staff who also would represent continuity of good relationships with the elderly they care for is seriously challenged by high staff turnover of 42% in the first 12 months of employment and 61% within two years, as well as increasing numbers of staff being from overseas and in some cases linguistic communication and cultural issues arise with the residents. These represent a continued source of concern for care providers<sup>433</sup>.

To a large extent the hospital complexities mentioned earlier reflect those elderly who stay for a longer or shorter time in the NHS hospital system, with the acute ones largely exiting the hospital if they survive their treatment. Clearly many have become the increase in the care home nursing care need identified.<sup>434</sup>

Public spending had been controlled firmly, NHS waiting lists had risen and Kenneth Clarke<sup>435</sup> as Health Minister, aware that public resources were very finite for his purposes and 'out of control' as far as supplementary benefit payments to fund care home stays were concerned but that private sector access to capital could be virtually infinite, aimed for an internal market to improve allocation of resources across the public and private sector.

Purchasing and provision was separated and the aim was to give patients more choice of provider and the information to make that choice. Initially purchasers

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<sup>433</sup> BUPA and CPA Paper (January 2011), *Ibid*, p. 3 and 12.

<sup>434</sup> One recent report by a commercial care provider that there has been a market failure where acute NHS Trusts have on the whole been unwilling to sub-contract post-acute care and rehabilitation to independent sector care home providers despite the massive cost differential between NHS hospitals and independent sector care homes – Laing & Buisson White Paper- *ibid*- Page 5.

<sup>435</sup> Secretary of State for Health in the Conservative Government of Margaret Thatcher (his term being 1988 – 1990).

continued to enter into large bulk contracts, the accent being on activity rather than outcome.

The Conservative Government passed the National Health Service and Community Care Act 1990,<sup>436</sup> seeking to address issues of curtailment of supplementary benefit payments for new care home residents from the Department of Health and Social Security, reduction of government funding to local authorities in conjunction with recognition of the need to stimulate private care home growth already taking place, enacting provisions which shifted the focus of care provision to a mixed economy of providers, and required local authorities to specifically take over the funding of independent sector residential and nursing home care from the social security system.

This Act also created a statutory duty on local authorities to assess people who may need community care services or other types of support, following a set of rules called the “care value base.” In some respects the Act may have been a missed opportunity for further policy reform for elderly care whilst the mood for change was present. Nevertheless the supplementary benefit income support component of care home funding had brought about enormous expansion of the care home private market in the 1980’s.

To constrain elderly care home demand for new applicants, some of whom had used choice of going into a care home as simply a lifestyle preference, the Act also required social services departments to use a care plan to assess elderly inpatients who may need help after discharge from hospital and others seeking care home placement, and by ensuring that money, which was originally available through

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<sup>436</sup>(1990, c.19). (sponsored by Kenneth Clarke – *Ibid.*).



social security to people in private homes who received income support, was transferred to social services departments to maintain people in their own homes.

This Act also reduced the role of local authorities by making them enablers rather than suppliers of social care for the elderly. Moreover, central government replaced funding through reimbursement of board and lodging through social assistance leaving the Attendance Allowance as the main direct payment from central government. In the same Act, there was the creation of NHS trusts,<sup>437</sup> and one of the more noteworthy provisions was the recognition of fundholding practices of general practitioners as a means of redistributing the power of use of resources at local level.<sup>438</sup>

What is described by some as ‘a quasi-market’ system emerges, but the role of the resource provision by tax payers remains. This may be summarised as follows:

*“In contrast to standard markets, these systems remain free at the point of delivery; no money changes hands between the final user....and the provider. Thus the state has retained its role as a funder of services within the welfare state, but the task of providing has been transferred from an integrated set of state owned and managed enterprises to a variety of independent provider organisations.”<sup>439</sup>*

Thus the Beveridge universalism philosophy was retained in changing economic circumstances, and the Labour Opposition accusation of the Conservative government seeking ways to abolish the NHS was averted.

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<sup>437</sup> Section 5. Competing with each other.

<sup>438</sup> Section 14.

<sup>439</sup> W. Bartlett, C. Propper, D. Wilson, J. Le Grand, *Quasi markets in the welfare state* (Bristol: SAUS Publications 1994).

### 5.3 The role of the family and others – informal care to the elderly

Michael Hill,<sup>440</sup> in his studies has emphasised the importance of the family as a provider of elderly care.<sup>441</sup> In the UK the emergence of smaller families and greater female participation in the workforce has witnessed the trend from caring within families to one of institutionally based long-term care. Nevertheless any such trends should not disguise the fact that whilst what may usefully be termed “formal care”<sup>442</sup> in the non-hospital sense includes home care, respite day care and care home care usually arranged by the local authority, now depends on institutions for delivery.

The vastness of “informal care”<sup>443</sup> consisting of the greater majority of elderly and other care delivered by an elderly person’s family, friends or neighbours or others providing personal care, practical help and co-ordination of care services, the number of which has grown by 11% in the decade 2001 to 2011, as has the intensity of their caring hours which have risen as has the number of them over 65 years of age. The NAO report estimates that the value of informal care is nearly £100bn per year.<sup>444</sup> See diagram below:<sup>445</sup>

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<sup>440</sup> Professor Michael Hill, University of Newcastle-upon-Tyne, who uses here OECD developed nations research and data as well as United Nations data.

<sup>441</sup> Michael Hill, *Social Policy in the Modern World: A comparative Text* (Oxford: Blackwell Publishing, 2006), Chapter 12 – “Ageing Societies.”

<sup>442</sup> Described as such together with “informal care” in the Report – *Adult social care in England : overview*- (11 March 2014) – National Audit Office (NAO) – Report of the Comptroller and Auditor-General to Parliament – Session 2013-2014 – HC 1102.

<sup>443</sup> NAO Report (11 March 2014), *Ibid*.

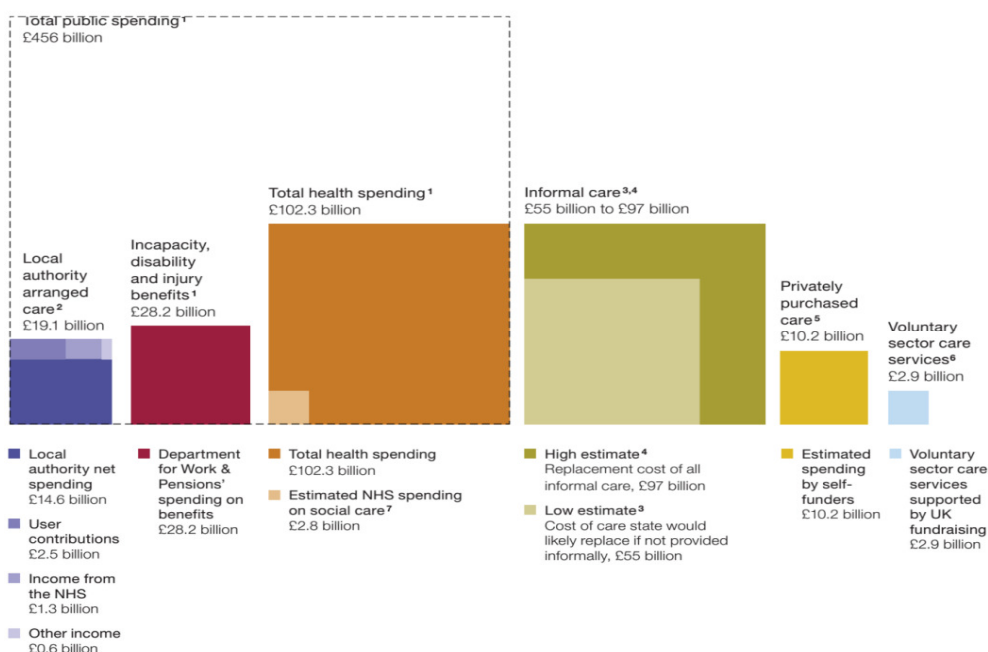
<sup>444</sup> NAO, *Adult Social Care in England: Overview* HC 1102 (11<sup>th</sup> March 2014) para. 1.6.

<sup>445</sup> HM Treasury, *Country and Regional Analysis* 2013, November 2013.

**Figure 2**

Estimates of the value of care for adults

The value of informal care outweighs state spending and compares to spending on health care



Source: 1) HM Treasury, *Country and Regional Analysis* 2013, November 2013; 2) Health and Social Care Information Centre, *Personal Social Services: Expenditure and Unit Costs – England, 2012-13*, December 2013; 3) LaingBuisson, *Domiciliary Care: UK Market Report* 2013, June 2013; 4) Carers UK, *Valuing Carers* 2011, May 2011; 5) Skills for Care, *The economic value of the adult social care sector in England*, February 2013; 6) National Council for Voluntary Organisations, *2010-11 UK estimate for adult and children's social services combined*, UK Civil Society Almanac 2013, accessed at: <http://data.ncvo.org.uk/>; 7) Department of Health, *2011-12 Programme Budgeting Benchmarking*, December 2012

Local authority provides important support for this part of care delivery. The Care Act 2014 provides an obligation on local authorities to provide support. This may be in the form of home helps, day care and also nursing care in care homes. Payments for these services may be from the user, the NHS, the voluntary sector and also local authorities. Currently there is a carer's allowance paid to low paid carers who provide at least 35 hours of care per week. Only minute numbers of carers receive such support.

## 5.4 Conclusions

The success of the NHS from the second half of the 20<sup>th</sup> Century as a healthcare provider delivers a variety of medical and related social services to large numbers of the elderly, and helps to prolong their lives. Beveridge's philosophy of

the elderly being embraced in the concept of universalism remains but restricted to the National Health Service in terms of acute and long term care treatments. In Chapter 7 we see how some sections of this NHS hospital care delivery meet regulatory failure.

Long term residential care is subject to a mixed variety of responses. Private sector interaction in care provision and private sector elderly care delivery growth accelerated from 1997. Indeed it recognised the realities of not redirecting funding into local government care home provision.<sup>446</sup>

Residential care was often seen as the last resort leaving families to take responsibility. There are also large discrepancies in the delivery of social services and support to the elderly across regions and according to marginal discretion operated by the local authority.

A large proportion of elderly care comes from families and friends that is largely unfunded from the state. The coexistence of public and private health care provision for the elderly continues, but the considerable issue of lack of ‘joined-up’ care persists despite attempts to rectify it.<sup>447</sup> Families, who provide much direct care to the elderly, are often the co-ordinators of the disjointed system as well as GP’s.

Families are also frequently at the centre of procuring the maintenance of their elderly in their own homes, much aided these days by modern equipment, skills, and with adaptation of premises more readily achievable than in the past, influencing some of the policy driven fall in care home numbers statistically visible.

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<sup>446</sup> Which earlier ‘traditional’ Labour governments would have done.

<sup>447</sup> The Labour government of 1999 attempted this by removing some legal barriers by Section 31 of the Health Act 1999 (1999, c.56) with important powers for the NHS and social services budgets to be pooled, for local authority agencies to provide some NHS services, and vice versa, and for each to delegate to the other responsibility for commissioning both health and social care services.

Today the 4% or so of the older population in long term residential care equates roughly with the proportion who were in-house paupers in 1892. An emphasis on community rather than state support, with a major provision of care by the private and charitable sectors is once again to the fore, although in more recent times two thirds of that care may be funded either wholly or in part by the state.

Party political engagement with the elderly has been a mixture of interventions that have varied from the Labour Party Manifesto in 1997 to the Royal Commission Report in 1999, the Royal Commissioners 2003 Statement and the intended effect of the Wanless Review to continue the debate that had been addressed by the Royal Commission in 1999.

It is clear that providing a coherent and over-arching system of elderly care regulation has to take account of the above analysis. Elderly care cuts across many different sectors – private, public, hospitals and care homes. Elderly care delivery and its medical requirements are in fact delivered across a system of hospitals, nursing homes and care homes which between themselves are hard to differentiate. It is in the nature of elderly care that it is multi-disciplinary cutting across a whole range.

## CHAPTER 6: Regulating Elderly Healthcare: The setting up of the Care Quality Commission (CQC)

### 6.1 Introduction

In this chapter, we turn to examine the question of the regulation of elderly health care and how this developed in the late 1970s and early 1980s, eventually leading to the establishment of the Care Quality Commission. This is an example of fast developing regulation that was largely in response to public unease, independent reports critical of health care professionals and reactive government intervention.

The role of the influential House of Commons Health Committee proved important as well as the setting up of the Royal Commission on Long Term Care in 1999. In the past two decades, health care in Britain has seen many regulatory failures as well as good practice and innovative performance. As independent report after report showed there were various systemic regulatory weaknesses. Amendments and reform became necessary in the aftermath of findings of avoidable deaths, poor care and negligent treatment of many patients.

The most vulnerable, particularly the elderly seemed most exposed to poor care. The current arrangements for the Care Quality Commission (CQC) under the Health and Social Care Act 2008 were not part of the original design.<sup>448</sup> Various statutory frameworks had applied including the 1984 regulatory Act<sup>449</sup> which in turn triggered local authority home closures, and these events were to 'pave the way' for

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<sup>448</sup> (2008, c.14).

<sup>449</sup> Regulatory Homes Act 1984- (1984, c.23).

the Care Standards Act 2000.<sup>450</sup> Further changes are envisaged under new legislation in 2014. It is unlikely that this will be the end of the saga as regulatory changes are improved to meet public expectations.

The chapter traces the steps in the history of elderly care regulation. It begins in 1999 with the findings of the Royal Commission on Health care, the influential Kennedy Report into the failures at Bristol Royal Infirmary, the creation of the Healthcare Commission and the Commission for Social Care Inspection leading eventually to the creation of the Care Quality Commission(CQC) from April 2009.

It is important to be aware that at its design and inception stage in 2008 the CQC was being established as a re-modelled healthcare regulator embracing Hampton principles of reduced numbers of overall regulators and 'light touch' regulatory intentions, but with a reasonably significant role.

The major and pivotal role it has now acquired after a catalogue of successive failings on its part arose from the near desperation of 'needing to make it work' in the light of evidence to Commons Health Committees of the presence of 're-structuring fatigue' with too many successive regulators. Complementing this direction of policy for development of the CQC are some strong recommendations in the Robert Francis Report discussed in Chapter 7 to retain and further enhance the CQC and its role.

## 6.1 The Royal Commission on Long Term Care 1999<sup>451</sup>

Longer lives bring more chronic, as opposed to purely acute, illnesses, such as Alzheimer's disease and dementia. An increase in stroke survival rehabilitation

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<sup>450</sup> (2000, c.14) - with its 38 statutory standards.

<sup>451</sup> *With Respect to Old Age: Long Term Care – Rights and Responsibilities* – A Report by the Royal Commission on Long Term Care (March 1999) – Cm 4192-1. The terms of reference are abbreviated together with the Executive Summary and Summary of Recommendations extract in Appendix 2 Part One.

processes gives rise to a new cohort of patients, when in past years they would have died. Accordingly the challenge to successive modern UK governments has been the increasing complexity of delivery systems and their oversight.

When new Labour came to power in 1997, Frank Dobson, and his Minister of State in the Department of Health, Alan Milburn, in that December, published “The New NHS Modern-Dependable” containing their initial vision for change to NHS structure, conceding that not all of the features of the Conservative internal market were worth keeping.<sup>452</sup> This broad continuity of party political consensus on the NHS is typical of past and current successive governments.

In autumn 1999, a MORI poll showed that public satisfaction with the NHS fell substantially between 1998 and 2000 from 72% to 58%. Alan Milburn became Secretary of State<sup>453</sup> encouraged co-operation with the private sector, even though here had been some disagreement within the party on this point.<sup>454</sup>

The Royal Commission was established by the new Labour Government on 17 December 1997. Its terms of reference included the brief to examine the short and long term options for a sustainable system of funding of long term care of elderly people, both when supported in their own homes and other settings and within twelve months to recommend how, and in what circumstances, the costs of such care should be apportioned between public funds and individuals, and to look into various other issues of long term care of the elderly.

This was the first time a Royal Commission had been set up to evaluate the National Health Service and its funding arrangements. This was the result of the

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<sup>452</sup> [www.nhshistory.net/chapter\\_6](http://www.nhshistory.net/chapter_6).

<sup>453</sup> Having been Minister of State at the Department of Health from May 1997 to October 1999 then stepped into the Secretary of State’s “shoes” in October 1999 (continuously therefore in the Blair New Labour Government). He remained Health Secretary until 2003.

<sup>454</sup> [www.nhshistory.com](http://www.nhshistory.com) *Ibid*.



Labour Party's Political Election Manifesto of 1997 commitment that "We will establish a Royal Commission to work out a fair system for funding long term care for the elderly" and that the present system was "confusing, unfair and unresponsive to people's needs".<sup>455</sup> Also there was broad reference was made to delivery of elderly care at "local level" as being in need of expert review in the same process.

The implications of the Royal Commission pointed to the need for management reform. At the same time as the Royal Commission was reporting there were a variety of reports detailing failures in health care delivery, the most significant was undertaken by Sir Ian Kennedy into Bristol Royal Infirmary and Children's Heart Surgery.

## 6.2 The Commission for Healthcare Audit and Inspection- The Healthcare Commission

The final report of the public enquiry into serious defects in the management of children's heart surgery at Bristol Royal Infirmary identified shortcomings in hospital cultures of care delivery.<sup>456</sup> The Report chaired by Professor Ian Kennedy, stated:

*"that the management of the NHS was quite distinct from its regulation, and the latter should not be under the day-to-day control of the Department of Health; it should be carried out by independent bodies within a statutory framework. Crucially, in this broad NHS hospital wide concluding finding that the regulatory approach should be patient-centred."*

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<sup>455</sup> [www.labour-party.org.uk/Labour](http://www.labour-party.org.uk/Labour) Party Manifestos/1997.

<sup>456</sup> Bristol Royal Infirmary Inquiry (Chairman: Professor Ian Kennedy) (18 July 2001) *The Report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995: learning from Bristol* (Cm. 5207).

This may seem similar to the economic regulators protecting consumers; however, the report distinguished its main regulatory proposal from the examples of regulatory structures formed out of economic and social regulatory needs. Kennedy states that:

*“By regulation we do not refer to the various economic approaches, such as through the market. Instead we mean the totality of the processes and systems for assuring and improving the safety and quality of healthcare, including the regulation of healthcare professionals and the regulation of the institutions in which they work.”<sup>457</sup>*

Although not especially mentioned, elderly care was considered in need of a general regulatory approach adopted in other parts of the NHS.

*“The new arrangements proposed...that the recently established regulatory bodies should be given greater independence from central government, and there should be an over-arching body to integrate and coordinate the activities of the others so avoiding the fragmentation of responsibility identified at Bristol. This would be a new Council.... The Council should validate all healthcare organisations, public or private. Some of the proposals were implemented by the National Health Service Reform and Health Care Professionals Act 2002<sup>458</sup>...and...through the Health and Social Care (Community Health Standards) Act 2003...This is the basic model which existed until 2009.”<sup>459</sup>*

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<sup>457</sup> *Learning from Bristol, Ibid*, p.261 – (reminiscent perhaps of the ‘synergy’ perspectives of successive Monitor annual reports implying that the resultant merged effect exceeds the simplicity of the component parts).

<sup>458</sup> (2002, c.17).

<sup>459</sup> 140 Health Act 2009, s 2; NHS, *The NHS Constitution: The NHS belongs to us all* (2009), 3, *Ibid*.

Section 1 of The Health and Social Care (Community Health and Standards) Act 2003<sup>460</sup> created NHS Foundation Trusts, the elite hospital trusts which were designed to have more freedom of management and action, and Section 2 of which founded the dedicated regulator of those new trusts.<sup>461</sup>

As part of the creation of the Foundation Trust and in line with the recommendations from the Kennedy inquiry into children's heart surgery at the Bristol Royal Infirmary (1998 – 2001),<sup>462</sup> the Healthcare Commission (Commission for Healthcare Audit and Inspection)(CHAI) was established independently of government by Section 41 of the 2003 Act<sup>463</sup> under Sir Ian Kennedy the author of the report and its first chair.

The Commission's main functions in England were to monitor and set standards for the performance of the new trusts. This included assessing the management, provision and quality of NHS healthcare and public health services; Reviewing the performance of all NHS trusts and award an annual performance rating to each trust; Regulating the independent healthcare sector through registration, inspection, monitoring complaints and enforcement activities. The Healthcare Commission was independent of the Government.”<sup>464</sup>

The new Commission followed a broad concept of ensuring regulatory standards of care laid down by Government were observed in practice. This proved

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<sup>460</sup> (2003, c.43). It had only one of the three segments (but arguably the largest of the three) of the eventual CQC which combined by amalgamation the HCC, the Commission for Social Care Inspectors (CSCI) and the Mental Health Act Commission (MHAC).

<sup>461</sup> To become known as Monitor.

<sup>462</sup> Among other high profile roles prior to this he was a member of the General Medical Council for 9 years. He advocated in the Bristol Report a departure from self-regulatory oversight to separate regulatory monitoring templates beginning with the Department of Health overseeing NHS hospitals.

<sup>463</sup> Schedule 6, Paragraph 1(1) of that Act provided the “The CHAI is not to be regarded as a servant or agent of the Crown..” and the remainder of that Schedule provided for independence of its functions, following Kennedy's recommendations in the Bristol Royal Infirmary Report.

<sup>464</sup> Quoted from [www.theguardian.com/Healthcare/Commission](http://www.theguardian.com/Healthcare/Commission):- (The Guardian having consistently demonstrated to the thesis writer its relatively objective and detailed healthcare reporting credentials in recent years where other organs of the media have often failed to report on specific issues)..

to be challenging. The Secretary of State was overall responsible for setting overall standards for the provision of healthcare but the new Commission could use the standards to monitor achievement. It was also timely in its creation as the role of healthcare policy became increasingly dominated by markets and patient choice. As we shall see these arrangements were maintained until 2009 when the HealthCare commission was subsumed into the Care Quality Commission.

The Healthcare commission marked a new era in health regulation. It was the first time that public regulation had been systemised into clinical and generic standards. Elderly care fell within the remit of the Healthcare Commission but the vision of Ian Kennedy that the Healthcare Commission could be a means opening up healthcare from the perspectives of patients and improving services, and not merely checking that pre-set standards are met had yet to be fully realised.<sup>465</sup>

The Healthcare Commission did not have a complete remit on its own. The regulation of residential homes including nursing and children's home came under separate regulation that was set up in response to the Royal Commission on Long Term Care.

### 6.3 The Commission for Social Care Inspection (CSCI)

Residential homes, nursing and children's homes were regulated in a rather "incoherent" way. One reason was because of the multiple responsibility was shared between local and central government – the health authorities and also the Department of Health. Regulation was limited and scattered. The Registered Homes

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<sup>465</sup> I Kennedy, *Learning from Bristol: Are We?* (2006), 62-71, at: <http://www.stateclaims.ie/ClinicalIndemnityScheme/publications/LearningfromBristol.pdf> (accessed 26 January 2010).

Act 1984<sup>466</sup> had been a significant milestone following the Nursing Homes Act 1975,<sup>467</sup> in that it consolidated into one statute nursing home regulation which had been overseen by the 1975 Act and care home regulation featuring in a series of Acts ending with the Health and Social Services and Social Security Adjudications Act 1983<sup>468</sup>. It removed the distinction between nursing and residential homes and local authority (and health authority) supervision of them, made provision for inspection and the driving up of standards by a new national body, the National Care Standards Commission (NCSC), and provided for the registration, regulation (including codes of conduct) and training of social-care workers.<sup>469</sup>

There were at least 38 national minimum standards scattered throughout legislation and regulations going back into the nineteenth century. In 1998, the Government proposed setting up eight regional Commissions for Care Standards. These were independent statutory bodies and over time new standards might be set by the Secretary of State including risk assessment and if necessary an appeal to an independent tribunal. Many of these ideas came from the Royal Commission on

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<sup>466</sup> 'The Registered Homes Act 1984 covers independent residential care homes, nursing homes, and mental nursing homes and private hospitals. Residential care homes, which provide residential accommodation with both board and personal care (but not nursing or mental nursing) are registered under Part I. Homes which provide nursing or mental nursing are registered under Part II. The definition of nursing home in Part II embraces a wide spectrum of provision from traditional nursing homes and mental nursing homes through to clinics, acute hospitals and psychiatric hospitals (Para.16). 'In November 1998 and March 1999, the government published two White Papers on its proposals for social services in England and Wales. Detailed proposals for the regulation of private and voluntary healthcare in England...' (Para.3). The relevant documents are '*Modernising Social Services (cm 4169)*, published in November 1998; *Building for the Future (cm 4051)*, published in March 1999; *Regulating Private and Voluntary Healthcare: A Consultation Document* [catalogue number 15994], published in England in June 1999' (cf. Para.4).

<sup>467</sup> (1975, c.37).

<sup>468</sup> (1983, c.41).

<sup>469</sup> In summary the act 'establishes a new, independent regulatory body for social care and private and voluntary healthcare services ("care services") in England to be known as the National Care Standards Commission'...'establishes new, independent Councils to register social care workers, set standards in social care work and regulate the education and training of social workers in England and Wales...'provides for the Secretary of State to maintain a list of individuals who are considered unsuitable to work with vulnerable adults' (Para.5). 'The main purpose of the Act is to reform the regulatory system for care systems in England and Wales. Care services range from residential care homes and nursing homes...For the first time, local authorities will be required to meet the same standards as independent sector providers' (Para.6.). 'These new arrangements will replace those set out in the Registered Homes Acts 1984' (Para.8).

Long Term Care who recommended establishing a National Care Commission to oversee the strategic policy. The Care Standards Act 2000, arguably was designed to achieve consistency in care delivery across the nation, replacing (so its authors claimed) room for manoeuvre in the 1984 Act under which words such as “adequate”, “sufficient” and “suitable” proliferated enabling home owners and registration authorities to negotiate over particular, varying, standards in different parts of the country.

In 2000 the creation of the new model regulator, the General Social Care Council (GSCC),<sup>470</sup> by the Care Standards Act 2000,<sup>471</sup> is described by Rodney Brooke, its new Chair in 2006/2007,<sup>472</sup> as having been tasked “to register and regulate the social care workforce that includes 75,000 qualified social workers, and 1.6 m other social care workers, not necessarily professionally qualified.” He also points out in his Report that it preceded the NHS Reform and Healthcare Professions Act 2002<sup>473</sup> which created the then Council for Regulatory Healthcare Excellence (CHRE)<sup>474</sup> which oversees the GMC and eight other healthcare professional regulatory bodies. Brooke’s conclusions included the view that since the Millennium there has been a move to more ‘intelligent’, targeted regulation.

The Commission for Social Care Inspection (CSCI) was established under the Health and Social Care (Community Health and Standards) Act 2003,<sup>475</sup> and

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<sup>470</sup> Abolished on 31 July 2012 by incoming Coalition legislation when its functions were merged with the Health and Care Professions Council (HCPC) – [www.hpc-uk.org](http://www.hpc-uk.org) See also – The General Social Care Council (Transfer of Register and Abolition- Transitional and Saving Provision) Order of Council 2012 (2012 No. 1480).

<sup>471</sup> (2000, c.14). (1984, c.23).

<sup>472</sup> Centre for the Study of Regulated Industries (CRI), University of Bath School of Management, - Regulatory Review 2006/2007 (10th Anniversary Edition).

<sup>473</sup> (2002, c.17).

<sup>474</sup> Now renamed the Professional Standards Authority (PSA).

<sup>475</sup> Section 1 of this Act established the new NHS Foundation Trusts. Section 2 established its regulator which subsequently became known as “Monitor”.

became operational on 1 April 2004.<sup>476</sup> Incorporating the work of the former Social Services Inspectorate (SSI), the SSI/Audit Commission Joint Review Team and the National Care Standards Commission (NCSC), the CSCI was the independent inspectorate for adult social care in England. CSCI was abolished in April 2009 replaced by a new single body, responsible for regulating adult social care and health called the Care Quality Commission (CQC).

The remit of the CSCI includes the regulation, review and inspection of all social care services for adults, in the public, private and voluntary sectors, and provides documentary evidence of the quantity and quality of social care services at both a local and national level.

The role and responsibility of the CSCI in relation to local social care services included registering care services in each local council area; inspecting all social care for adults in the public, private and voluntary sectors, issuing a publicly available inspection report; publishing performance ratings of local council social services; and taking enforcement action when services do not meet minimum standards. The Commission had the power to issue notices to service providers to enforce the regulatory requirements of the National Minimum Standards.<sup>477</sup>

Events unfolded with some degree of speed and with unexpected consequences. A few weeks after being set up the budget speech in 2005 announced that it was decided to merge the two bodies by 2008- the Healthcare Commission and the Commission for Social Care Inspection. At the same time the responsibility for regulating child care was moved to Ofsted under the Education and

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<sup>476</sup> Section 42 of the Act actually created the CSCI.

<sup>477</sup> [www.localgovglossary.com/Commission+for+Social+Care+Inspection](http://www.localgovglossary.com/Commission+for+Social+Care+Inspection). It is noteworthy that regulating the care worker voluntary registration provisions in Section 228 of the Health and Social Care Act 2012. Are a further attempt to ensure effective regulation.

Inspections Act 2006.<sup>478</sup> The decision to make such important changes came about because of the pressure on the Government to de-regulate. The Hampton Review included a basic policy message that too many regulatory organisations existed and the economic case for merger proceeded on an economic analysis rather than as a result of any specific health policy. The outcome was the creation of the Care Quality Commission.

#### 6.4 The Care Quality Commission: Setting up and rationale

The Care Quality Commission (CQC) which came into operation from 1 April 2009 and assumed responsibility from the Healthcare Commission, the Commission for Social Care Inspection (CSCI), and the Mental Health Act Commission (MHAC).<sup>479</sup> There followed an independent research study published by the Department of Health in November 2006<sup>480</sup> and its successor report responding to the statutory consultation exercise in October 2007.<sup>481</sup>

The rationale for the CQC appears as a mixture of pragmatic politics as well as cost cutting in response to the perception explained in the Hampton Report that there were too many regulatory bodies. The Parliamentary activity programme which

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<sup>478</sup> (2006, c.40).

<sup>479</sup> “*The NHS Improvement Plan*, (published by the Department of Health in 2004) and “*Health Reform in England: update and next steps*” (published in 2005) set out the main strands of reform, which include diversity in provision of services, increased patient choice, and a stronger patient voice and stronger commissioning. These reforms require changes to be made to the regulatory framework” (See *The NHS Improvement Plan: Putting People at the Heart of Public Services*, The Stationery Office, June 2004). “in the 2005 budget statement, the Chancellor announced plans to reduce the number of public services inspectorates. This included the creation of a single inspectorate for social care and health by merging CHAI and CSCI. The Department of Health had already announced plans to bring together CHAI and MHAC in 2004 following a review of *Arm’s Length Bodies*” (See *Reconfiguring the Department of Health’s Arm Length Bodies*, July 2004). Quotations taken from Health and Social Care Act 2008, (2008 c.14), Explanatory Notes: Background and Summary, Part 1 – The Care Quality Commission, p.1, [www.legislation.gov.uk/ukpga](http://www.legislation.gov.uk/ukpga).

<sup>480</sup> *Independent research study: The future of health and adult social care regulation* – (Department of Health – 27 November 2006) – [www.dh.gov.uk/en](http://www.dh.gov.uk/en).

<sup>481</sup> *The future regulation of health and adult social care in England: response to consultation* – (Department of Health 24 October 2007 (ref;283676) – [www.dh.gov.uk/en/publications](http://www.dh.gov.uk/en/publications).



that had simultaneously passed the Hampton principles into law with the Regulatory Enforcement and Sanctions Act 2008,<sup>482</sup> Section 72 of which imposed a duty on regulators “not to impose or maintain unnecessary burdens” and to implement proportionality in carrying out regulatory functions. Thus a “light touch” regulatory scene had been set for the coming into being of the CQC. Finally it is noteworthy that the new CQC was also to take over responsibility for the Mental Health Act Commission.

The rationale for the new body was the development of commissioning in the health service. The Department of Health’s report of the Future Regulation of Health and Adult Social Care in England (2006) explained that the NHS was “embarked on an ambitious programme of reform to devolve the organisation and management of healthcare to a local level...to improve the patient experience.” As a result “it is necessary to ask what alterations if any are required to the regulatory framework for health and adult social care in England – both in terms of *functions* (what regulation needs to happen) and *architecture* (who does what).” Hence is presented “a piece of research into the impact of system reform on regulatory requirements that will inform Department thinking in this area.”<sup>483</sup>

The Department of Health Report draws upon economic regulatory models, broadly based upon the supposedly ‘tried and tested’ utility regulatory templates, with footnote references to various academic and other economists with significant focus being placed upon the market-lead aspects of healthcare delivery, risking being too economically designed. It looked into considerable detail in its 34 pages at the theory of market competition, UK regulatory models for the telecoms, mail and rail industries, and lessons learned from those, and healthcare regulation in

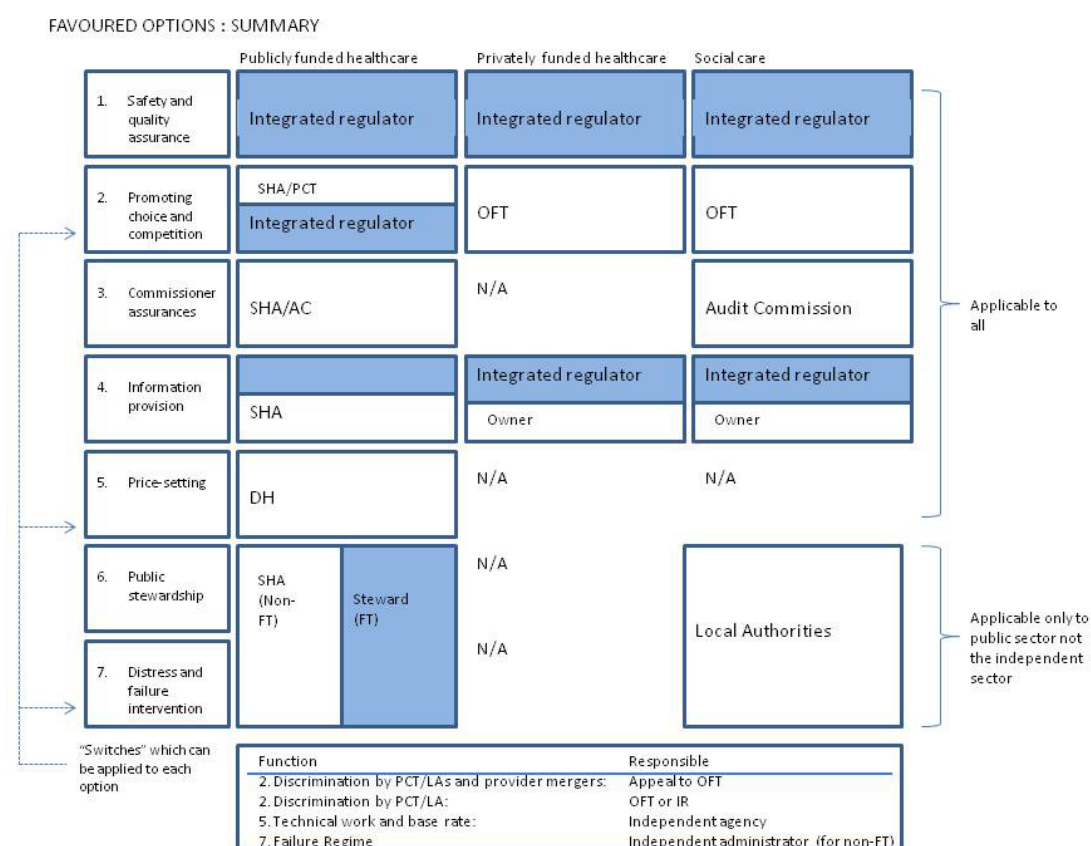
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<sup>482</sup> Consecutive Chapters 13 and 14 of the 2008 Statute Book respectively.

<sup>483</sup> Introduction, *Ibid*, p.4.

Australia, Germany, Holland, Norway and Singapore (and lessons learned from each), functionality required for England with its publically and privately funded healthcare and social care, and three argued options for the future model the first listed one of which, on the diagram, was put forward as the “preferred option.”<sup>484</sup>

Exhibit 9 (November 2006 Report)



Source: Team analysis

Then followed a period of consultation in which the then Health Secretary Alan Johnston, on 24 October 2007.<sup>485</sup> Alan Johnson summarised the various responses that “showed widespread support for an integrated and independent regulator.” He agreed legislation to establish the CQC that “will therefore work to

<sup>484</sup> Report of 27 November 2006, *Ibid*, Exhibit 9 (page 34) – *The integrated regulator*. (An amalgam of other models).

<sup>485</sup> *Ibid*.

minimise the cost and impact of on-site inspections and data collections by adhering to the Government's Principles of Good Regulation.<sup>486</sup> The CQC was expected to adopt a regulatory approach that was: proportionate – and appropriate to the risk posed; transparent; consistent; accountable; and targeted only where needed.”<sup>487</sup>

The new arrangements for the CQC had much in common with a generic approach to regulation. These included the following: Sanctions and enforcement powers proposed were a statutory warning notice requiring improvement, formal caution, regulator's fine, in lieu of prosecution, restrictions imposed on regulated activities, temporary suspension, cancellation of registration and criminal prosecution.<sup>488</sup>

Thus the embryo of the CQC, an entirely new model regulator, was formed by the Government, and informed by prevailing attitudes to regulation at that time including the useful analysis of the Report of the National Audit Office (NAO) of 5 July 2006 about how to merge statutory regulators.<sup>489</sup> The merger of the Healthcare Commission and the Commission for Social Care Inspection was to take place over a period of time leading to the eventual creation of the Care Quality Commission.

Perhaps this was an attempt to avoid the 'abolish and start again' temptation which decades of previous political experience had been shown to draw criticism from taxpayers on money wasting grounds.<sup>490</sup> Ironically this merger achieved what Ian Kennedy had hoped for that patient care would ultimately set the tone of the regulatory system. However, as we shall see this was to take some time to achieve

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<sup>486</sup> Available at [www.brc.gov.uk/publications/principlesentry.aspx](http://www.brc.gov.uk/publications/principlesentry.aspx) - referring to Richard Macrory 'widening the regulatory toolbox' post-Hampton, but driven by Hampton principles.

<sup>487</sup> *Ibid*, para. 1.11.

<sup>488</sup> *Ibid*, para. 3.28.

<sup>489</sup> Report of the Comptroller and Auditor General to Parliament (NAO) (5 July 2006) – *The creation of Ofcom: Wider lessons for public sector mergers of regulatory agencies* HC 1175 (Session 2005-2006).

<sup>490</sup> Including substantial aggregated redundancy payments, and often then re-employing some of those made redundant.

and is certainly a work in progress. It is also clear that there are a variety of influences at work including economists and auditors who are accountants by training, with overlapping professional skills, but without the lawyers, HR advisers and other commercial specialists that form part of the regulatory framework. This marked a revolution in setting clinical standards and generic standards of healthcare across the whole sector.

## 6.5 The Care Quality Commission (CQC): Early years

The Health and Social Care Act 2008<sup>491</sup> (HSCA), Section 1(1) of which created the Care Quality Commission as a 'body corporate', and Section 1(2) of which abolished the regulators which it replaced, namely the Commission for Healthcare Audit and Inspection (formerly the Commission for Healthcare Improvement), the Commission for Social Care Inspection and the Mental Health Act Commission.

The legal entity possessed by the CQC was a corporate body without Crown status, compared, for example, with regulators such as the Food Standards Agency (FSA) and the Health and Safety Executive (HSE) both of which are non-ministerial government departments, the latter containing a notably tripartite membership structure comprised of government officials, persons from the employer side of industry and trade union officials.

That the CQC does not replicate the earlier regulatory templates and is an entirely new brand of governance, but nevertheless it has Department of Health ministerial and civil service structural support, and ultimately direct Parliamentary accountability.

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<sup>491</sup> (2008 c.14).

The HSCA and subsequent statutory remit to the CQC is still expanding in transitional terms. This is likely to continue to be a feature of the new body for some time as it copes with new challenges in its role and functions. It currently regulates all NHS Trusts,<sup>492</sup> adult social care providers including day care services and home care services, independent health care providers, including private hospitals, independent ambulance services, hospices and private doctors and dentists. Since April 2013 the CQC has been expanded to cover all GP practices, and the Health Secretary has made it clear that there are plans to expand its remit even further and develop links with other providers of healthcare services.<sup>493</sup>

This intention is commented upon by the Comptroller and Auditor-General,<sup>494</sup> who states that “proposals to extend the Commission’s role risk distracting the Commission from its core work of regulating health and social care.”<sup>495</sup> The role of the CQC is detailed in the background and summary of the Health and Social Care Act 2008:

*“Chapter 1 part 1 of the Act establishes a new body called the Care Quality Commission (“the Commission”). The Commission will be responsible for the registration, review and inspection of certain health and social services in England (but not any care services that are regulated by the Chief Inspector of Education, Children’s Services and Skills (‘CIECSS’)). It will replace CHAI*

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<sup>492</sup> Its predecessor statute, the Care Standards Act 2000 (2000, c.14), had regulated providers of adult social care and independent healthcare, so the HSCA 2008 remit is much wider.

<sup>493</sup> [www.dh.gov.uk](http://www.dh.gov.uk).

<sup>494</sup> An officer of the House of Commons by status – National Audit Act 1983 (1983, c.44) – Section 1(3).

<sup>495</sup> Executive summary (penultimate paragraph) – NAO Report 2 December 2011, *Ibid*. Apparently successful in terms of not taking over the Human Tissue Authority (HTA), further mentioned below.

*and CSCI. The functions currently performed by MHAC will be transferred to the Commissions and the Welsh Ministers.”<sup>496</sup>*

*“Chapter 2 of Part 1 creates a system of registration for providers and, in some cases, managers of health and adult social care...All providers, including NHS providers, will be brought within the ambit of registration...Once a provider or manager has been registered, the Commission will be responsible for checking continued compliance...and will have a range of sanctions...The Commission will have a wider range of powers to suspend registration”<sup>497</sup>*

*“Chapter 3 of Part 1 requires the Commission to carry out periodic reviews of care provided by or commissioned by Primary Care Trusts (‘PCTs’) or English local authorities to see how well the bodies reviewed are doing. It also requires the Commission to review health care provided by PCTs, English NHS Trusts and NHS Foundation Trusts.”<sup>498</sup>*

Powers of the Care Quality Commission (CQC) as a regulator<sup>499</sup> broadly embrace inspection, monitoring, guidance and intervention in improvement notice and prosecution terms with care homes, hospitals, ambulances, care services in peoples own homes, doctors and G.P’s activities, dentists, clinics, community services and mental health services The Care Act 2014 is adding to these powers of market oversight to guard against provider failure in April 2015.

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<sup>496</sup> Health and Social Care Act 2008, Background and Summary: Part 1 – The Care Quality Commission, p.1 Section 9.

<sup>497</sup> *Ibid*, p.1 Section 10.

<sup>498</sup> *Ibid*, pp.1-2, Section 11.

<sup>499</sup> ‘Regulator’ and ‘Regulation’ are defined on Pages 14 and 13 of Chapter 1 of this thesis.

The CQC's role and emerging responsibilities is indicative of how much complexity and technical skill is required to be a regulator of health care.<sup>500</sup> The CQC is subject to audit by the National Audit Office<sup>501</sup> and its annual reports are subject to 'Annual accountability hearing with the Care Quality Commission' by the House of Commons Health Committee.<sup>502</sup> Early criticism of registration of providers was noted by the Committee who concluded that "It is regrettable that this was neither foreseen nor addressed before the vast majority of providers had already fought through the process."<sup>503</sup> In the case of dentists it was noted that "...It is astonishing that it could ever have been considered sensible for small dental practices to work through the same process as a large hospital."<sup>504</sup>

It was clear that the CQC struggled to cope with its new role and function during the transitional period to it being set up and established.

## 6.6 The Care Quality Commission: learning from mistakes

The shortcomings in setting up the Care Quality Commission as it attempted to establish its role, function and operation should not be surprising. Many of these

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<sup>500</sup> Even though there is the attraction that they are in adjoining buildings. Opposition to the extension of the CQC's role to include The Human Tissue Authorities was recently made clear by the Royal College of Surgeons of England who said that the safe and ethical use of human tissue is complicated and requires specialist expertise and appropriate regulation which is sufficiently different from the general regulation of health and social care currently undertaken by the CQC.

<sup>501</sup> Consultation on the draft Care and Support Bill (26 October 2012) – Response from the Royal College of Surgeons. [www.rcseng.org.uk](http://www.rcseng.org.uk).

<sup>502</sup> House of Commons Health Committee – Ninth Report – (Session 2012-13) - [www.parliament.uk/healthcom](http://www.parliament.uk/healthcom). See: That Committee's report of evidence taken by it on 28 June 2011 and earlier, and its consequent September 2011 findings picks up much the same criticisms and shortcomings as are to be reflected some three months later in the NAO report, but with some more focus in certain areas such as the onerous challenges facing providers trying to get registered.

<sup>503</sup> *Ibid*, para. 72

<sup>504</sup> *Ibid*, para 73.

were exposed simply because it had to merge two distinct organisations during a time of major changes in the NHS itself.<sup>505</sup>

The perception in 2011 by the CQC itself of how it was fulfilling its statutory role,<sup>506</sup> that it was ‘rising’ to the spectrum of challenges it faced as a comparatively new body, makes interesting analysis against the (obviously much more objective). The NAO report on its activities noted that:<sup>507</sup>

*“There is a gap between what the public and providers expect of the Commission and what it can achieve as a regulator.”<sup>508</sup> This finding ...arising from a misunderstanding of what it can achieve as a regulator.”<sup>509</sup>*

*“The Commission underspent against its budget for 2009/10, and 2010/11 partly because it had a significant number of staff vacancies...The Commission has been unable to fill vacancies promptly, and was subject to the government wide recruitment constraints.”<sup>510</sup>*

*“The Commission has not so far achieved value for money in regulation of the quality and safety of health and adult social care. It is not clear to us exactly where the balance of responsibility lies between the Commission and the Department for failing to achieve value for money, but it is clear that responsibility is shared.”<sup>511</sup>*

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<sup>505</sup> Health Committee – 2013 Accountability Hearing with the Care Quality Commission- Sixth Report (Session 2013-14) (22<sup>nd</sup> January 2014) – HC 761 (See below).

<sup>506</sup> Care Quality Commission – ‘The state of health care and adult social care in England’ - An overview of key themes in care in 2010/11 report to Parliament 15 September 2011 (HC 1847).

<sup>507</sup> The NAO having only a Parliamentary scrutiny of government departmental spending function under the National Audit Act 1983 (1983, c.44), and therefore a narrower remit than Parliamentary Committees, *Ibid* (2 December 2011).

<sup>508</sup> *Ibid*, summary p.7, para. 9.

<sup>509</sup> HC; 1665, 2010-2011, *Ibid*, Executive summary – penultimate paragraph

<sup>510</sup> £139M compared with an aggregate of £175M for the last year of its three predecessor bodies.

<sup>511</sup> Julia Black, *Ibid*, summary, para. 19 – A very remarkable objective finding in the context of accountability issues, reflected by Professor Julia Black in her paper of 2013.



*“The Commission has faced challenges in staff morale. It inherited three sets of pay and conditions from its predecessor bodies...Morale has been negatively affected by inconsistencies in pay and conditions, with staff doing the same job on different pay scales.”<sup>512</sup>*

The NAO Report provides a dysfunctional picture of a new statutory body endeavouring to unify and harmonise its inherited constituent parts.<sup>513</sup> There were also concerns about the adequacy of its funding and its ability to recruit suitable staff<sup>514</sup>. This was helped by further demands that the CQC’s role should be extended further. In March 2012 PAC Report for example suggested that “The Commission should not take on the functions of the Human Fertilisation and Embryology Authority at this time”.<sup>515</sup>

On a more positive note the core activities of the CQC had received welcome endorsement from the Royal College of Nursing (RCN) report from a survey of its nursing staff in care homes in England<sup>516</sup> found that members responding were in support of CQC inspections, with 89% agreeing that inspections of care homes are required to ensure that quality and safety is maintained.<sup>517</sup>

However, within the management of the CQC all was not well. The March 2012 Report of the Commons Public Accounts Committee,<sup>518</sup> after taking evidence from a number of people including Una O’Brien, Permanent Secretary Department of

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<sup>512</sup> *Ibid*, part Two, para.2.18

<sup>513</sup> Some being UK government controlled, but many lie within the spectrum of EU directives/other EU legislation, Human Rights Act 1998 Convention rights issues, and those judicially reviewable generally.

<sup>514</sup> Office for Budget Responsibility (H.M. Treasury) – Public Expenditure Statistical Analyses 2011.

<sup>515</sup> PAC Report – Conclusions and recommendations, *Ibid*, para.8. (despite the fact that they share a building with them).

<sup>516</sup> Persistent challenges to providing quality care – An RCN report on the views and experiences of frontline nursing staff in care homes in England (Royal College of Nursing – 20 March 2012).

<sup>517</sup> *Ibid*, Executive Summary, para.8.

<sup>518</sup> Public Accounts Committee – Seventy-Eighth Report – The Care Quality Commission: Regulating the quality and safety of health and adult social care (Published 30 March 2012).

Health,<sup>519</sup> Cynthia Bower, CQC Chief Executive and Amanda Sherlock, CQC Director of Operations noted that there was a high turnover of staff and that “Staff leaving the Commission have been made to sign compromise agreements<sup>520</sup> containing gagging clauses”<sup>521</sup> and by using such clauses in preventing departing employees from pointing out problematic management and operational issues which may have promoted improvement..<sup>522</sup> The PAC duly noted that “The Commission is the third regulator for health and adult social care in the last decade. None of the witnesses we heard from was in favour of further reorganisation, stressing that the existing arrangements need to be made to work better.”<sup>523</sup>

Serious concerns about the management and operational life of the CQC emerged from the House of Commons Health Committee – 2012 Accountability Hearing with the CQC in 2012 that were published in a report on 9 January 2013.<sup>524</sup> The House of Commons Committee found that there had been fundamental and serious failure in a number of arguably comparatively quite basic aspects of its management and governance, pointing to cultural flaws in the way it had been run for more than four years.

One of its Board members since 2008, Kay Sheldon, had continually raised with the Chair and Chief Executive and other board members what the Committee considered to be legitimate concerns about management and cultural issues over a four year period and had demonstrated that she had been consistently boycotted

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<sup>519</sup> Therefore the statutory Accounting Officer for departmental expenditure under the Government Resources and Accounts Act 2000 (2000, c.20) designed to strengthen expenditure accountability following the judgement in *R v. Secretary of State for Foreign Affairs, ex.p The World Development Movement Ltd.* [1994] EWHC Admin.1.

<sup>520</sup> By using the general power to do so in S.203(2) Employment Rights Act 1996 (1996, c.18).

<sup>521</sup> PAC Report, *Ibid*, para.5.

<sup>522</sup> Hence on 8 June 2012 the new CQC chief executive, David Behan, was appointed as a “trouble-shooter” (cf. *The Guardian*, Wednesday 9 April 2014, ‘A reluctant rescuer of crisis-hit CQC’).

<sup>523</sup> PAC Report, *Ibid*, para 8, The management and governance.

<sup>524</sup> House of Commons Health Committee – (9 January 2013) - 2012 accountability hearing with the Care Quality Commission (Seventh Report of Session 2012-2013) HC592.

and “stonewalled.”<sup>525</sup> She survived as a Board member, whilst the Chief Executive and the Chair have both felt compelled to resign within a few months of each other.

Kay Sheldon’s evidence provides a chronological account to the Committee of attempts since early after her appointment to the Board on 1 December 2008 to use proper channels to raise what she observed to be issues of concern or merely seeking to participate in evaluation and decision making processes relay a quite extraordinary sequence of events in an apparent culture where she was sidelined for not ‘towing the line’ of the Chair and majority of the Board and a culture of bullying.<sup>526</sup>

Eventually, the Chair, Jo Williams,<sup>527</sup> removed Kay Sheldon from the Board. Kay Sheldon provided oral evidence to the Stafford Hospital Public Enquiry<sup>528</sup> on 28 November 2011 about CQC failings in that connection and, in the wake of so doing, reached a point on 30 March 2012 when arguably she took the best possible step by getting legal representation which ascertained that the attempts to remove her were unlawful (and susceptible to judicial review). Her solicitors also wrote to Margaret Hodge MP, Chair of the Public Accounts Committee at the House of Commons, and a letter from that Chair to the Secretary of State for Health apparently confirmed “that the concerns (Kay Sheldon) had raised had been viewed by the Public Accounts Committee as ‘substantially true’ and expressing concern.”<sup>529</sup>

This remarkable turning point in Kay Sheldon’s treatment due to her perseverance in pursuit of truth and justice saw off two Chairs and two Chief

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<sup>525</sup> Using Kay Sheldon’s own words (*Ibid*, at Ev 51).

<sup>526</sup> Supported by staff survey evidence by the union Unison at the time (March 2012).

<sup>527</sup> Since resigned as Chair.

<sup>528</sup> Robert Francis QC, *Ibid*, Final Report (6 February 2013); Robert Francis Q.C. subsequently, on 4 June 2014, became a non-executive board member of the CQC, thus adding his extensive experience to CQC’s quest to improve itself.

<sup>529</sup> *Ibid*, at Ev.55.

Executives so as to make the CQC a much better body today than it would have been,<sup>530</sup> and was followed by legal reinstatement procedures including an employment compromise agreement<sup>531</sup> in which document her solicitors successfully resisted a “gagging clause”, which would have preventing her speaking out publically.<sup>532</sup>

One aspect of the role of the CQC that emerged at this time is its role in regulating elderly care. Evidence given to the House of Commons Health Committee by the Relatives & Residents Association (R & R A), an organisation that is a charity and pressure group that “speaks up and speaks out on behalf older people in care homes is important.. It is the only national charity for older people providing a daily helpline which concentrates entirely on residential care for this age group.”<sup>533</sup> Its evidence suggested that: the “CQC is not acting as an agent for improvement as required in their government legislation; the CQC does not have sufficient expertise in the care home sector; that specialists with expertise in care homes should be recruited to inspect care homes; and finally that the group is deeply concerned that CQC as an organisation is viewed as lacking in expertise and capability and is not viewed as an authoritative body on what represents good quality care in care homes;

*We do not agree with the concept of ‘generic’ inspectors and are campaigning for specialist inspectors to inspect care homes who can properly distinguish between poor and excellent care and good, bad or mediocre care homes.*<sup>534</sup>

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<sup>530</sup> The CQC website appears to have been framed so as to disguise this negative image information.

<sup>531</sup> Pursuant to Employment Rights Act 1996 (1996, c.18) – Section 203 - which introduced this alternative procedure to going to an Employment Tribunal with an agreed deal for the tribunal to approve.

<sup>532</sup> On 3 July 2013 the CQC website ([www.cqc.org.uk](http://www.cqc.org.uk)) announced her reappointment as a board director of the CQC when her fixed term expires in October 2013.

<sup>533</sup> Report, *Ibid.* Ev. 29.

<sup>534</sup> Report, *Ibid.* Ev. 29-31.

The CQC in the face of major criticisms changed its personnel and streamlined its operations. The CQC's own website,<sup>535</sup> shows that its Chief Executive is now David Behan, with a local authority director of social services background and presumably on £200k per annum,<sup>536</sup> and that three of its Board of just six members (other than the Chair and the Chief Executive) have been changed in the past two years.

In reality the CQC is running an enormous business across the country with a financial and operational remit which should surely be more on a commercial PLC (public limited company) management model, with several of those members of that Executive Team actually having some commercial background.<sup>537</sup> One improvement in this deficient management structure was achieved very recently by the realisation that the Chief Executive had to be a full member of the board.<sup>538</sup>

There were also changes in the professional background and education of its senior management team including its chair. The CQC Board of Directors, for its first four years of existence, courted in effect a fundamental weakness in the management structure. To compound this, the outgoing Chair of that Board, Dame Jo Williams (another former local authority social services director),<sup>539</sup> when she resigned her role described as 2/3 days per week,<sup>540</sup> her replacement was required to be "an individual of exceptional calibre (required) to challenge, provide direction and enable the CQC to be a first-class regulator in health and social care." For that

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<sup>535</sup> Accessed for this purpose on 20 October 2012 after clearly having been revamped in response to criticism.

<sup>536</sup> Which was paid to his predecessor Cynthia Bower according to the CQC Annual Report 2010/2011.

<sup>537</sup> The author draws here on his background as a solicitor advising company boards of directors and his own board membership of charitable and other companies.

<sup>538</sup> House of Commons Health Committee – First Special Report (17 May 2013) – HC 154 – Government Response- "The CQC Chief Executive is now a member of the Board...The new Chief Inspector of Hospitals...will have a place on the Board."

<sup>539</sup> Arguably entirely the wrong background to head an enterprise which requires commercial experience as has been demonstrated by those running even charitable companies (per the author's personal experience as a commercial solicitor).

<sup>540</sup> By the Cabinet Office – Public Appointments (accessed 20 October 2012) (Vacancy No. E12-22) That figure is more akin to the 'expenses' that ought to be on offer to the right candidate.

(formidable) task and for presiding over a £200k per annum Chief Executive, the salary is only £63K maximum.<sup>541</sup>

In the event David Prior, Chair of Norfolk and Norwich NHS PCT, was appointed as the new Chair with effect from 28 January 2013. He has since engaged with an enormous, and arguably impossible, task to grapple with a flawed regulatory model, but as a qualified barrister, following a Cambridge University education, and some years of private corporate and commercial experience, has arguably some of the skills and background which have been sorely missing from the CQC boardroom table.<sup>542</sup>

The Report of the House of Commons Health Committee <sup>543</sup> published in January 2014 made a number of findings and recommendations that showed that the CQC had taken steps to answer its critics. This included greater clarity from the CQC as to its aims and objectives. This is in contrast to the findings made in 2012 that the CQC suffered from standards that were “cluttered and opaque”.

## 6.7 Conclusions

Healthcare in general and elderly care in particular was given little public regulation for many years. Explicit standards of care emerged from a number of factors that have led to the establishment of the CQC. In the 1990s the Department of Health had begun to take a more interventionist approach over healthcare.

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<sup>541</sup> Cabinet Office advertisement, *Ibid*.

<sup>542</sup> See [www.cqc.org.uk](http://www.cqc.org.uk). A remarkable exception and change of direction to this lack of expertise being the appointment (June 2013) of Michael Mire to the CQC Board he being a former McKinsey partner of many years standing. Camilla Cavendish, also in June 2013, a high profile journalist who, in an independent Report (July 2013), has advised the coalition government on the weaknesses and strengths of the system of support workers and health care assistants in NHS and social care settings, and Robert Francis Q.C. of the Stafford Hospital Enquiry (4 June 2014).

<sup>543</sup> House of Commons Health Committee – (22<sup>nd</sup> January 2014) – 2013 Accountability Hearing with the Care Quality Commission – (Sixth report of Session 2012-13) HC 761.

Frameworks set by Government were greatly influenced by the commissioning aspects of the National Health Service. National Service Frameworks were in vogue including the National Institute for Clinical Excellence (NICE) and a Commission for Health Improvement. The catalyst for change came with the establishment of the NHS Foundation Trust and the Royal Commission on Long Term Elderly care had a formative role. Then undoubtedly the influence of Sir Ian Kennedy's Bristol Royal Infirmary 2001 Report was epoch making in terms of his finding of the overall need to separate the roles of regulator and regulatee.

The setting up of the Healthcare Commission and the Commission for Social Care Inspection proved short-lived. Ironically this came about not because of the clear logic of having a unified single regulator but because of the influence of regulatory thinking at that time. In the decade beginning in 2000/2001, Hampton principles of reducing the burden and having less regulation across the UK statutory regulatory world as a whole gained prominence.<sup>544</sup> This regulation became known as "lighter touch" regulation, which was to bring about the perceived need on the part of government to enact the Health and Social Care Act 2008<sup>545</sup> and to bring into being the enlarged regulator, the Care Quality Commission (CQC), which became progressively exclusively responsible, as an independent body, for registration of a wide body of health care and social care delivery persons and organisations (public and private), and their inspection, monitoring and regulation. .

The institutional structure to regulate elderly care has also coincided with tighter controls on local government spending and resource allocation. There are also some important themes emerging at this time. First, came the introduction of

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<sup>544</sup> *Reducing administrative burdens: effective inspection and enforcement* (March 2005) – Philip Hampton – HM Treasury – [www.hm-treasury.gov.uk/Hampton](http://www.hm-treasury.gov.uk/Hampton).

<sup>545</sup> (2008, c.14) – bringing the CQC into full effect on 1 April 2009 by merging three regulators, the CHAI, the CSCI and the Mental Health Act Commission.

personal responsibility through the creation in 2005 of personal budget schemes. Various payments might be directed to the elderly for their care and maintenance. The evident public-private mixture of delivery systems is apparent during this period. This has proved to be decisive in mapping the future direction of elderly care.

There is cross-fertilisation of ideas at work. The relationship between the system of regulation of elderly care delivery as such, and the debate about the public/private funding of the same discussed in this chapter, raises the issue that although financial resourcing is not directly about the CQC and regulation there is the clear implication that if funding is inadequate then the quality of care delivered will be further eroded, so that the CQC will end up in effect 'regulating the government's (austerity) policy'.

The successes and failures of the regulatory system is evident from the evolution of the Care Quality Commission, a pivotal regulator with statutory accountability overseeing most of public and private elderly and other care delivery. Also relevant is the experience of Monitor, an economic regulator of NHS foundation trust hospitals at its inception,<sup>546</sup> to complete more of the regulatory picture.<sup>547</sup>

As we have seen the early foundation and foundational steps taken by the CQC did not prove effective at first. Amidst mounting criticism the CQC has been reactive and innovative. The role of the House of Commons Select Committee on Health, the National Audit Office and the Public Accounts Committee has been important. Under a mixture of pressures from the public and from the work of various committees the CQC has changed its culture, its board composition and its expertise

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<sup>546</sup> Established by section 2 of the Health and Social Care (Community Health and Standard) Act 2003 (2003, c.43).

<sup>547</sup> In Chapter 5, Human Rights Act issues are primarily visited through the eyes of the Equality and Human Rights Commission having reported that breaches of human rights are being identified and dealt with in care homes in general, and in particular that the 'reach' of the Human Rights Act to elderly care elsewhere is inappropriate.



templates, and become an inspection led and proactive organisation. In its short life it has taken tentative steps in the direction set out by Sir Ian Kennedy that the regulatory structure should be patient led and patient centred.

Those processes of accountability have been of undoubted value in procuring change for the better for the CQC which very broadly only accords with Prosser's argument for legitimacy in the constitutional forms of accountability and oversight where the presence of regulation at all is a recognised way for the state to address the protection of the vulnerable and the elderly.

The Commons Health Committee's finding, in the above analysis, of unclear division of responsibilities between the CQC and the Department of Health underscores Julia Black's argument in various regulatory roles of the "blurring of lines" of responsibility in the accountability debate.

Finally, also in the general accountability perspective we see from Chapter 7 how the regulatory failures identified by the Francis Public Inquiry bring about in the Care Act 2014 Government acceptance of Francis' recommendations to retain the CQC and enhance its role.

## CHAPTER 7: Elderly Care and the Francis Report 2013

### 7.0 Introduction

The Healthcare Commission (HC), before its amalgamation into the Care Quality Commission (CQC), launched a review into the standards of care at Stafford Hospital, primarily motivated by data showing usually high death rates. As a result of the HC's adverse preliminary findings, the then Health Secretary Alan Johnson commissioned an independent enquiry in July 2009, led by Robert Francis QC. In March 2010 the first report was published,<sup>548</sup> and this was followed up by a Public Inquiry into the events at Mid Staffordshire, building on the findings of that first report. The public inquiry contained over 290 recommendations, published on 6<sup>th</sup> February 2013 and this was followed by follow up analysis undertaken by the newly established Care Quality Commission. The Care Quality Commission (CQC) became the recipient of many of the lessons to be drawn from the Francis Reports. The period of the Francis Reports covered standards of patient care from 2005 to 2009.

The Second Report was undertaken more formally under the Inquiries Act 2005 and was known as the Mid Staffordshire NHS Foundation Trust Public Enquiry<sup>549</sup> and was published on 6 February 2013 made significant recommendations for the general future of the NHS in terms of patient quality and its delivery as well as future regulation. The first report on "The Mid Staffordshire NHS Foundation Trust Enquiry" of 2010<sup>550</sup> (24<sup>th</sup> February 2010)<sup>551</sup> was informal, largely conducted in private, and contained 18 major recommendations for the management

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<sup>548</sup> Including Robert Francis recommending that a public enquiry be held.

<sup>549</sup> [www.midstaffspublicenquiry.com/report](http://www.midstaffspublicenquiry.com/report).

<sup>550</sup> The Mid Staffordshire NHS Foundation Trust Enquiry (5 February 2010) – Robert Francis QC – [www.midstaffsenquiry.com/assets/docs](http://www.midstaffsenquiry.com/assets/docs).

<sup>551</sup> (2005, c.12).

and structure of health care delivery. The Government responded and accepted most of the main recommendations and many of the recommendation became part of the Care Bill 2013/14 now the Care Act 2014.<sup>552</sup>

The Francis Reports came at a critical stage in the early life of the Care Quality Commission. The Commission had to accept that many of the findings of the Francis Report that required a readjustment in the role of care regulation, not least in the role of the Care Quality Commission.

Specific findings by Francis affecting the CQC's future role were the need for regulators to establish a 'cultural barometer' to assess cultural health in care organisations, patient-centred care delivery, bridging of gaps between regulators functions, giving the CQC enhanced oversight of care delivery standards, and not to be tempted to abolish the CQC but instead give it a much enhanced role by evolution.<sup>553</sup> Much of this has been enacted by the Care Act 2014.<sup>554</sup>

This chapter is focused on the findings of the Francis Report and their significance for elderly care in terms of protecting patients and placing patient care at the centre of regulatory priorities.

## 7.1 The Findings of the Francis Reports: Placing Patient Care as a Priority

Robert Francis, as a leading lawyer,<sup>555</sup> was specifically chosen for the task to ensure that his findings were sufficiently robust and credible.<sup>556</sup> The terms of

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<sup>552</sup> HM Government Department of Health, *Hard Truths, the Journey to Putting Patients First* (13<sup>th</sup> November 2013)

<sup>553</sup> Francis Public Inquiry Report – *ibid.* Recommendations 1, 5, 19 (connected with 35), 20 (connected and expanded at 47,49 and 74), and 53 respectively.

<sup>554</sup> (2014, c.23).

<sup>555</sup> In particular the public enquiry of 1999 into the Alder Hey Children's Hospital Liverpool organ removal scandal, where he represented the University of Liverpool as a party appearing at that enquiry. - [www.serjeantsinn.com/barristers/sirrobertfrancis](http://www.serjeantsinn.com/barristers/sirrobertfrancis).

reference of the Francis Public Inquiry and its main function, akin to the first enquiry, was not to attribute individual blame as such but to make findings about how the experience of past mistakes could be explained in terms of what went wrong and what lessons could be gained from past mistakes.<sup>557</sup> The aim was to discover what further action was needed to ensure that public confidence in the Mid Staffordshire NHS Trust might be established.<sup>558</sup>

The Francis Report 2013 identified many failings and shortcomings in patient care.<sup>559</sup> One of the most disturbing was the perception that the culture of the NHS Trust was “not conducive to providing good care for patients or supportive working environment for staff.”<sup>560</sup> Consequent upon the financial crisis and the implementation of staff cuts, the Management Board of the Trust had lost sight of its fundamental responsibility in ensuring that care was safe, and the multiple layers of management had not interacted satisfactorily. The full extent of the problems included systemic malfunctions resulting in several hundred deaths from 2005 to 2009 (including many elderly people whose families perceived that they were being hospitalised for routine treatment and were not in terminal decline) and more specific findings; see Appendix 4 (annexed). Recommendations included better management

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<sup>556</sup> See [www.serjeantsinn.com](http://www.serjeantsinn.com). Robert Francis’s credentials as a practising barrister as a very experienced clinical negligence litigator (acting for claimants and defendants) with previous public enquiry experience.

<sup>557</sup> The complexities of this are set out in detail in the judgement of Eady, J. in the case of *LILLIE v. NEWCASTLE CITY COUNCIL* [2002] EWHC 1600 (QB) when he reviewed earlier case law, and further reference to detail on the complexities of qualified privilege under Section 15 and Schedule 1 of the Defamation Act 1996 (1996, c.31) and at common law (slightly modified by the Defamation Act 2013 [2013, c.26]) can be accessed at [www.yourrights.org.uk/yourrights/right-of-free-expression/defamation/qualifiedprivilege](http://www.yourrights.org.uk/yourrights/right-of-free-expression/defamation/qualifiedprivilege).

<sup>558</sup> Firstly, under the Inquiries Act 2005 Section 2(1) makes it clear that such inquiries, commissioned by a minister, are without any “...power to determine any civil or criminal liability”, an outcome perhaps understandable for many. Secondly, Section 37(3) contains a statutory cross-reference to the general law of defamation, which emphasises that people conducting such enquiries only enjoy protection under the law of defamation to the extent of qualified privilege only (unlike, for example, the level of absolute privilege attaching to anything said in proceedings in Parliament), and, therefore, the same level attributed to evidence given in proceedings in a court of law.

<sup>559</sup> And almost certainly replaced findings against specific people with ‘watered-down’ generic and systemic findings of blame.

<sup>560</sup> House of Commons Library: *The Francis Report (Report of the Mid-Staffordshire NHS Foundation Trust public inquiry and the Government’s response* SN/SP/6690 (2<sup>nd</sup> December 2013).

training and that there should be a more professional environment surrounding care delivery. The first inquiry had looked at the various failings within the Trust. The Public Inquiry was more widely drawn to assess the operation of commissioning, supervising and the various regulatory bodies responsible for the Trust. The 290 recommendations were far reaching and designed “to change the culture and make sure patients come first by creating a common patient centred culture across the NHS.”<sup>561</sup> The structure of openness and transparency as well as candour was expected to inform the working of the NHS.

Specifically on the regulatory side, Francis advocated a much expanded CQC supervisory role, by evolution, and not to be tempted to replace it as a regulator. Also, that the gaps between the involvement of the regulators drove the case for the merger of Monitor into the CQC.

### 7.3 Managing patient care

The main findings of the Francis Inquiry relate to setting up an appropriate structure of fundamental standards and compliance measures. This is an attempt to provide a set of fundamental principles that create a genuine partnership with patients ensuring that the management of hospitals is joined up and at one with the main responsibility of ensuring patient care. The Francis Report at modest cost for a public inquiry introduced some important principles.<sup>562</sup> In summary, these include openness, transparency and candour. The specific requirement of being truthful to patients and open and honest is seen as a fundamental aspect of building trust in the NHS particularly amongst vulnerable people who are elderly and ill.

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<sup>561</sup> See the Patients First and Foremost: the initial Government Response to the Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (26<sup>th</sup> March 2013).

<sup>562</sup> One assessment being £1.7M – [www.bbc.c.uk/news](http://www.bbc.c.uk/news) (16 March 2013).

Additional support for caring amongst the nursing staff is articulated in terms of ensuring that nursing staff, have their caring culture periodically checked, are given a stronger voice and are able to set out their concerns and needs, including generic care issues. Establishing a strong sense of leadership is essential with only “fit and proper persons” being eligible for service. Many of these recommendations have been taken forward in new legislation now the Care Act 2014 set out below.

#### 7.4 Elderly care- Professions and their responses to the Francis Report

There are clear signs that the Francis Report is being taken seriously. The new report by the Royal College of Physicians (RCP)<sup>563</sup> offers a way forward to implement many of the Francis “principles” of good patient care. The RCP is an important and influential member representative professional body and its website points out that it provides “...physicians across 30 medical specialities, including geriatric medicine, with education, training and support.”<sup>564</sup> Is...an independent body representing over 27,500 fellows and members worldwide.....and advise and work with government, the public, patients and other professions to improve health and healthcare.”<sup>565</sup>

The RCP’s Report’s introduction makes reference, in the context of elderly care quality experience, to regulatory and other failures that are evident from recent high profile reports and examples. The findings in February 2011 by the Parliamentary and Health Services Ombudsman investigating ten cases of NHS care

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<sup>563</sup> Royal College of Physicians (September 2012) – *Hospitals on the edge? The time for action* ([www.rcplondon.ac.org](http://www.rcplondon.ac.org)).

<sup>564</sup> As became patent before Beveridge’s NHS could be implemented in the 1946-1948 intense negotiation with Government experience.

<sup>565</sup> RCP Report, *Ibid*, Introduction.

of older people,<sup>566</sup> had conclude that there had been serious neglect. The Francis Report, following the Public Inquiry,<sup>567</sup> into that hospital saw that many of the most basic elements of healthcare for elderly patients were neglected, and finding that “staff displayed insufficient care for patients dignity with some left in degrading conditions and others inadequately dressed.”<sup>568</sup>

The RCP Report, suggests that steps should be taken to ensure that:

- All health professionals to promote patient-centred care and to treat all patients with dignity at all times.
- The redesign of services to better meet patients’ needs. This may involve consolidation of hospital services and hospital closure. The planning and implementation of new services must be clinically, not NHS management, led.
- The reorganisation of hospital care so that patients can access expert services seven days a week.
- Access to primary care to be improved so patients can see their GP out of hours, relieving pressure on A&E services.

Thereafter, the RCP Report moves on to cultural and other issues finding that with hospital staff that “...the system continues to treat older patients as a surprise, at best, or unwelcome, at worst. Much more can be done to prevent unnecessary hospital admission and readmission.” The RCP makes another related finding that across the national system “...areas with integrated services for older people have

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<sup>566</sup> *Care and compassion?* (February 2011) [www.ombudsman.org.uk](http://www.ombudsman.org.uk).

<sup>567</sup> [www.midstaffpublicenquiry.com/report](http://www.midstaffpublicenquiry.com/report).

<sup>568</sup> [www.midstaffpublicenquiry.com/report, Ibid](http://www.midstaffpublicenquiry.com/report, Ibid).

lower rates of bed use. These hospitals also tend to have lower admission rates and deliver good patient experience.”<sup>569</sup>

Hospital staff cultural issues receives some comment that “...research shows that medical and nursing staff often feel that older patients ‘shouldn’t be there.’<sup>570</sup> Being perceived as the ‘wrong patient at the wrong ward’ has been shown to reduce the quality of care, building attitudes of resentment from both medical and nursing staff.” It follows that there is a particular need to address the needs of older patients with chronic conditions occupying acute care beds.

The Report’s chapter entitled “Increased clinical demand” analyses a different prism of statistics, again from fellows and members’ personal experiences in the hospital system, observing that “....the number of general and acute beds has decreased by a third in the past 25 years, and yet during the past 10 years there has been a 37% increase in emergency hospital admissions and a 65% increase in secondary care episodes for those over 75.”<sup>571</sup>

There are also concerns that “...emergency hospital admissions account for over a third (35%) of all hospital admissions...(and)...the NHS has been slow to develop comprehensive effective alternatives to admission.” Further, significantly in the “joined-up” care debate, that “integration of primary and social care and primary and secondary care have both been shown to reduce hospital admissions.”<sup>572</sup>

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<sup>569</sup> RCP Report, *Ibid*.

<sup>570</sup> By W. Tadd in *Dignity in practice – an exploration of the care of older adults in acute NHS trusts*. London; Pearson 2011 ([www.panicoa.org](http://www.panicoa.org)).

<sup>571</sup> C. Imison (and others) - *Older people and emergency bed use – Exploring variation* (Research paper 9 August 2012 – The Kings Fund - [www.kingsfund.org.uk](http://www.kingsfund.org.uk)).

<sup>572</sup> Sourced by the RCP report, Sarah Purdy – *Avoiding hospital admission* (Research paper – 16 December 2010 – The Kings Fund), *Ibid*.



In the context of NHS hospital elderly bed use, the King's Fund research published in August 2012 had several findings that again place an emphasis on elderly care and acute bed shortages.

"The potential reductions in emergency bed use by patients over 65 are considerable; PCT's with the highest bed use tend to have excessive lengths of stay for patients for whom hospital was a transition between home and supported living;<sup>573</sup> Areas that have well developed, integrated services for older people have lower rates of hospital bed use. Areas with lower bed use also deliver a good patient experience and have lower readmission rates."<sup>574</sup> "Increased public expectation leading to more self-referral to NHS care is a possible explanation of the increasing admissions as are changes in clinical decision making and defensive medicine."<sup>575</sup> Also, "the majority of additional A&E attendances are for minor conditions."<sup>576</sup>

The King's Fund also makes the finding that "...many healthcare professionals working with patients over 80 will not have had geriatric training despite the significant percentage of these patients in hospitals." – an indictment of modern government inaction with current demographic pressures progressively producing more and more elderly people needing hospital care.

The RCP members also find that the King's Fund report is helpful in identifying hospital practice across the nation ranked continuity of care as their greatest concern in the current health landscape. A quarter of RCP fellows and

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<sup>573</sup> PCT being a simplistic reference to a NHS acute hospital, the "supported living" being a reference to persons with a disability generally but the large number of elderly in that situation in particular.

<sup>574</sup> C. Imison (and others), *Ibid*, Key messages, p.1.

<sup>575</sup> The American litigation culture having arrived here was cited to the author of this thesis by a Birmingham A&E consultant as being a great challenge which had resulted in more intense and lengthy medical attention per patient with the obvious time and cost implications. The same consultant specifically corroborated the much increased public expectations culture with junior doctors in particular having to cope with what he described as a "blame" society.

<sup>576</sup> RCP report, *Ibid*. (The A&E consultant interview *Ibid*. blamed the new 2004 GP contracts for this problem).

members rated their hospital's ability to deliver continuity of care as poor or very poor.<sup>577</sup> As the RCP report concludes:

*"A report from the King's Fund<sup>578</sup> shows that older people are more likely than others to be readmitted to hospital within a short time of discharge and are often moved around in hospital...[and in circumstances where there is] no consultant taking overall responsibility for their case; ...[and] can be moved four times because of the need for a bed in a particular specialty [and]... decisions are often made by bed managers and patient care is often transferred to a new consultant without any formal handover."<sup>579</sup>*

Many RCP members consider that older people who do not fit neatly into a specialty get moved several times during a hospital stay, each time changing their ward nursing team and often their medical team. This is 'not good care.' It also lengthens hospital stays which "studies show that every ward move puts at least one day on the length of a stay."<sup>580</sup>

This is consistent with the view that the elderly need special staffing requirements and that hospital care delivery generally, and elderly care in particular and that increasing specialisation in medicine has led to increasing survival rates for single conditions. There is also concern about "fragmentation of acute care services (e.g. stroke, acute myocardial infarction, respiratory failure) has removed many consultants from the general medical admitting role and certain specialties (e.g.

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<sup>577</sup> RCP report, *Ibid*, *Fractured care*.

<sup>578</sup> J. Cornwell – King's Fund – 27 March 2012 – *Continuity of care failing frail older people in hospitals* ([www.kingsfund.org.uk](http://www.kingsfund.org.uk)).

<sup>579</sup> RCP report, *Ibid*.

<sup>580</sup> RCP report, *Ibid*, which the NHS Confederation says is costing the NHS £545,000 per day (approx £200M per year – NHS Confederation briefing *Papering over the cracks: the impact of social care funding on the NHS* (September 2012 – Issue 248)

neurology, dermatology) effectively provide no junior or consultant level staffing for this activity in the majority of hospitals.”<sup>581</sup>

There is also some concern that perhaps over specialisation can bring its own difficulties in developing patient care.<sup>582</sup> This may mean that the obvious benefits of modern specialist care have negative consequences when the care from specialists is poorly coordinated, especially with older people with complex needs. “...Leadership is needed to clarify the roles...”<sup>583</sup>

Another paper found that patients admitted at the weekend do not get diagnostic tests as quickly as those admitted during the week, reflecting availability of specialised personnel, but in terms of consultant presence on the accident and emergency unit for more than 4 hours per day, seven days per week, found that such produced a reduced 28 day readmission rate.<sup>584</sup>

Additionally the RCP says that “...mortality for acutely ill patients is higher for those admitted at nights and at weekends when less experienced doctors are on site...often 10% higher.” Also that “...a NCEPOD report found that the care of patients who underwent resuscitation following in-hospital cardiopulmonary arrest to be less than good in 70% of cases. Deficiencies were noted in consultant involvement.”<sup>585</sup>

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<sup>581</sup> RCP report, *Ibid*.

<sup>582</sup> Sourced from the GMC report – *The state of medical education and practice in the UK 2011* London GMC 2011 – [www.gmc.uk.org/publications](http://www.gmc.uk.org/publications).

<sup>583</sup> RCP Report, *Ibid*, *Fractured care* (chapter)

<sup>584</sup> Sourced from – S. Purdy – Kings Fund paper 16 December 2010 – *Avoiding hospital readmissions* (p.27) ([www.kingsfund.org.uk/found](http://www.kingsfund.org.uk/found))

<sup>585</sup> National Confederation Enquiry into Patient Outcome and Death – *Time to intervene?* - A review of patients who underwent cardiopulmonary resuscitation as a result of an in hospital cardiopulmonary arrest. London. NCEPOD 2012 and RCP Report, *Ibid*, p.43 – *Out of hours care breakdown*.

## 7.5 The Care Act 2014 - Principal Components and Structure

One of the major outcomes of the Francis Report is to take forward unprecedented changes in the way elderly care is to be treated.

*“The bill is intended to give effect to the policies requiring primary legislation that were set out in the White Paper Caring for our future: reforming care and support (Cm 8378, July 2012), to implement the changes put forward by the Commission on the Funding of Care and Support, chaired by Andrew Dilnot, and to meet the recommendations of the Law Commission in its report on Adult Social Care (Law Com 326, HC 941, May 2011) to consolidate and modernise existing care and support law. The Bill also gives effect to elements of the Government’s initial response to the Mid Staffordshire NHS Foundation Trust Public Inquiry that require primary legislation. Patients First and Foremost – Initial Government Response to the Report of The Mid Staffordshire NHS Foundation Trust Public Inquiry (Cmd 8576).”<sup>586</sup>*

Sections 1 to 7 set out the general responsibilities of local authorities to describe a broader care and support role towards the local community and, in some respects, the aim of reducing or delaying an elderly person’s likelihood of need for care.<sup>587</sup> They also provide for a person’s journey through the care and support system and for assisting people with information.<sup>588</sup>

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<sup>586</sup> Explanatory Notes to Bills: Care Bill [hl] 2013, Background and summary, p.2 para.5.

<sup>587</sup> Overview of the structure, *Ibid*, Part 1 – Care and Support: “Part 1 sets out the legal framework for the provision of adult social care in England” (P.2 para.9). “Clauses 1 to 7 set out the general responsibilities of local authorities. They describe local authorities’ broader care and support role towards the local community, including services provided more generally, for instance those with the aim of reducing needs” (P.2 para.10).

<sup>588</sup> [www.legislation.gov.uk/ukpga/2013/23](http://www.legislation.gov.uk/ukpga/2013/23) - Care Act 2014. – Sections 8-39. The Care Act received the Royal Assent on 14 May 2014

Residential care becomes one of many options that service providers may wish to fund. Accordingly eligibility shifts from the current entitlement, based on need, to one of a number of criteria based on financial considerations.

The provision for comparisons of information and advice about care and support services in their local authority area for all persons requiring care (whether or not they require local authority support) is innovative and there is also the statutory purpose that such persons receive services that prevent their care needs from becoming more serious; can get information they need, and have a good range of providers to choose from.

The provisions also make it clear that local authorities must arrange services that help or prevent people deteriorating.<sup>589</sup> The general provisions for local authority powers and duties include provision to create a cap on the care costs and for local authorities to enter into deferred payment agreements with individuals. From April 2016, the Government will introduce a cap so as to render individuals responsible for their care costs up to £72,000. The figure is intended to be adjusted annually.

The new legal right from April 2015 for people to defer paying care home costs is intended to prevent them being forced to sell their homes during their lifetime. Specifically local authorities will have the power to take an enforceable mortgage on an elderly person's home and charge interest, etc., set out in secondary legislation.<sup>590</sup>

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<sup>589</sup> The thesis writer's personal experience was with his elderly father between 2003 and 2008 using the Warwickshire Care System was that only because it was partially local authority funded and was Council support and advice and information made available. A lack of that support and advice without the local authority involvement was felt to be a considerable potential disadvantage at the time. The new provisions certainly widened matters considerably to the advantage of elderly people generally and their family and supporters.

<sup>590</sup> Care Act 2014, *Ibid*, sections 34 and 35. Pursuant to the authority's general power to charge in section 14.

The legal entitlement of individual people requiring care will also be that they have a personal budget part of the care and support plan which the local authority will compile.<sup>591</sup> This is part of the system of the individualising budgets rather than the past system of the funds following the care institution.

Also in Part 1 of the care and support provisions in the Act is provision for provider failure and market oversight.<sup>592</sup> The oversight of registered care and support providers by the Care Quality Commission (CQC) is set out in the Act as well as local authorities' responsibilities for ensuring continuity of care where a provider sustains business failure and ceases to provide a service.<sup>593</sup>

Focus is required on existing company law which applies to hundreds of private company care providers. In terms of financial transparency each of these qualifies as a "small company" without statutory obligation to file accounts at Companies House for public inspection if, for example, its annual turnover does not exceed £6.5 Million or has no more than 50 employees.<sup>594</sup> Currently, therefore, many residential care and nursing homes have no obligation to display even historic figures of that type. Statutory access, if it existed but it doesn't, to a care company's taxation accounts might help with this transparency issue, even for the prospective resident.<sup>595</sup>

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<sup>591</sup> Care Act 2014, *Ibid*, section 26.

<sup>592</sup> Care Act 2014, *Ibid*, sections 48 to 55.

<sup>593</sup> This is a direct result of the Southern Cross collapse *Ibid*. "Clauses 47 to 54 provide for the oversight of registered care and support providers by the Care Quality Commission (CQC), and set out local authorities' responsibilities for ensuring continuity of care where a provider sustains business failure and ceases to provide a service". (Explanatory Notes to Bills: Care Bill [hl] 2013, Background and summary, Overview of the structure, Part 1 – Care and Support, p.2 para.13.

<sup>594</sup> Companies Act 2006 (2006, c.46) – Section 382.

<sup>595</sup> It remains to be seen how ministerial regulations under the 2014 Act might improve upon this unsatisfactory situation- criticised as such by the care home market overseer Laing & Buisson – *Strategic Commissioning of Long Term Care for Older People :can we get more for less?* (September 2014) – Paragraph 3.2.5- [www.laingbuisson.co.uk](http://www.laingbuisson.co.uk).

Section 53 of the Care Act 2014 sets out “criteria ... for market oversight.” It provides for the Health Secretary to make regulations to specify the “criteria” for determining the financial stability of “a registered care provider,” necessarily including those arising under the Insolvency Act 1986, for which they have no corporate, commercial or professional expertise. This could give rise to significant regulatory problems whereby the profit motivated care provider could easily mislead the regulator.

Then in Section 55 (Assessment of financial sustainability of care provider) there is potentially scope for further issues. The provisions whereby the Care Quality Commission (for which their Chief Executive, David Behan, has already admitted in January 2014 to the Parliamentary Health Select Committee that he possesses no staff with the skills to carry out these statutory functions) are to be given power for an actual or potentially insolvent care provider “to develop a plan for how to mitigate or eliminate the risk”<sup>596</sup> and/or to “arrange for, or require the provider to arrange for, a person with appropriate professional expertise to carry out an independent review of the business”<sup>597</sup> is firstly going to force the provider to engage the main people in the private insolvency accountancy marketplace<sup>598</sup> who advertise themselves as “corporate recovery” consultants.<sup>599</sup>

Probably a further compounding measure for the actually or potentially insolvent care provider is the CQC recovery power in Section 55 (4) of the new Act

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<sup>596</sup> Section 55 (2)(a) of the 2014 Act, *Ibid.*

<sup>597</sup> Section 55 (2)(b), *Ibid.*

<sup>598</sup> Who are nevertheless Licenced Insolvency Practitioners under the Insolvency Act 1986 (1986, c.45).

<sup>599</sup> In the writer’s personal experience, as a practising solicitor in Birmingham engaging with and advising these sorts of consultants, there is no doubt that they are the equivalent of “funeral directors” in the insolvency advisory business whose motive is to persuade any business that it should proceed into receivership or liquidation so that their costs of so doing, at a rate of hundreds of pounds per hour, are virtually guaranteed for payment as a statutory first charge (under the Insolvency Act 1986) on whatever assets of the failing business they can get their hands upon.

from the care provider of the costs of engaging such corporate recovery consultants. Adding further substantial debt on to a provider's existing crisis is questionable.

Accordingly, the above provisions are potentially problematic in practice.

#### 7.5.1 Care Standards

There are extensive further provisions to engage difficulties with NHS Trusts and NHS Foundation Trusts, increasing the power of the regulator of the latter, Monitor. Extended are Monitor's powers to impose additional licence conditions<sup>600</sup> and the appointment of a Trust special administrator. This appears to be an incomplete response to Robert Francis's criticism of Monitor's performance in waiting for the other statutory bodies before completing its own duties,<sup>601</sup> and its need to merge with the CQC.

There are provisions for performance ratings.<sup>602</sup> The CQC is being required to conduct periodic reviews, assess performance and publish reports in respect of service providers to allow for a meaningful comparison of services on a star rating basis.

#### 7.5.2 Health

The establishment of Health Education England "to ensure that there is a sufficient number of healthcare workers with the skills and training to provide health services in England"<sup>603</sup> as a non-department public body, reflecting one of Robert Francis's recommendations, as well as The Health Research Authority, the changes

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<sup>600</sup> On top of their Health and Social Care Act 2012 powers to licence NHS goods and services providers.

<sup>601</sup> [www.midstaffspublicenquiry.com/report](http://www.midstaffspublicenquiry.com/report), *Ibid*, Executive Summary in para. 1.52 to 1.57 – which Francis used as a ground to urge merger of monitor with the CQC.

<sup>602</sup> Care Act 2014, Section 91, *Ibid*.

<sup>603</sup> Explanatory Notes, *Ibid*



giving the former intended greater independence with clearly defined duties but still having a duty to report to the Secretary of State for Health and Parliament ultimately.

Having emerged from parliament in May 2014,<sup>604</sup> this will be a very significant piece of legislation for it achieves a number of purposes. Firstly, it gives effect to the Law Commission Report on restructuring the multiplicity of statutes back to 1946, affecting elderly care and other care, into a consolidation of care and support law by using “a single, clear statute which is built around the person not the service.”<sup>605</sup> And secondly, it puts the individual at the centre of the statutory care delivery system which will significantly benefit the elderly individual of society.

## 7.6 Conclusions

The Francis Report points to a major regulatory failure, triggered largely by Stafford hospital’s own pre-recession financial crisis and the effect on morale at all levels of their care delivery, which in consequence impacted negatively on the hospital’s care culture. Health and Safety Executive prosecution followed with a substantial fine on the Foundation Trust,<sup>606</sup> but comparatively little professional body disciplinary intervention nor police prosecution was evident as both sets of the terms of reference for Francis precluded individual blame. Thus Francis’ function was designed necessarily in that way.

Separately the Government asked the Law Commission to review doctors, nurses and healthcare professional’s regulatory structures, known to be too diverse from old legislation. The Law Commission reported back with the expected reform

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<sup>604</sup> (2014, c.23).

<sup>605</sup> Adult Social Care (Law Commission) (10 May 2011 HC941).

<sup>606</sup> Stafford Crown Court in April 2014 fined the Trust £200,000 in connection with the systems which led to the death of a patient, the subject of the Francis Enquiry- [www.eversheds.com](http://www.eversheds.com)

proposals just as the Care Act 2014 was going through its last stages in Parliament.<sup>607</sup> The Care Act 2014<sup>608</sup> recently passed by Parliament represents some positive constructive regulatory steps in the right direction, but there is far more to do and to be achieved.<sup>609</sup> The Law Commission 2011 report had highlighted the need for tighter professional regulation.<sup>610</sup>

It is clear that the Francis Report has highlighted many of the issues that surround preventative measures to care for the elderly. This includes preventing and detecting problems, taking action promptly and ensuring systems of robust accountability. This is seen as not only concerned with regulatory practices but also with the NHS culture and the setting of robust and enforceable professional standards of conduct.

Strong and robust management is shown to be needed to drive the required theoretical and practical cultural standards of care delivery required, but chain reactions resulting in negative cultural outcomes on the elderly patient experience must surely be hard to humanly circumvent at times of great financial austerity. There is surely a connection between ready availability of finance and rectifying poor standards by training expenditure or other improvement means. There must therefore surely be more “Stafford” crises to come before sufficient, and difficult to deliver cultural change, comes about.

Nevertheless more robust CQC oversight arrangements are already evident.

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<sup>607</sup> Law Commission Report – *Regulation of Health and Social Care Professionals* (2 April 2014) with attached draft Bill proposing a new single statutory framework for the nine diverse professional bodies which was largely accepted by the Government on 29 January 2015- [www.lawcommission.justice.gov.uk/areas/Healthcare\\_professions](http://www.lawcommission.justice.gov.uk/areas/Healthcare_professions).

<sup>608</sup> (2014, c.23).

<sup>609</sup> Not least local authority implementation problems from lack of database information – “Adult Social Care in England: An Overview” (13 March 2014) – National Audit Office Report to Parliament – Executive Summary HC1102 – ‘Key Findings’ – para. 18.

<sup>610</sup> For statutory structural reforms to NHS and care legislation and a re-focusing of care needs around the individual with a corresponding complex nine part re-definition of the “well-being” concept.

## CHAPTER 8: Elderly care accountability and human rights

### 8.0 Introduction

Delivery of care to the elderly, whether in a private home or a local authority owned home, or indeed in a NHS or other hospital, depends on systems of accountability and transparency to ensure that it is of good quality and is being well delivered.<sup>611</sup> Hence the need identified in Chapter 7 to drive reform of aspects found to be unsatisfactory. In this chapter the potential for elderly care to be protected in terms of human rights and further systems of accountability and transparency are examined.

Elderly care breaks down into two broad categories; care in house for relatively healthy elderly people who require general care assistance and help, and care for elderly patients who are suffering from a range of chronic conditions and often these are multiple conditions. Meeting the challenge of elderly care has long been required. In late 2012, the RCP reported that since the inception of the NHS in Great Britain in 1948 the population which it served had grown by some 12 million people. Those people were now living longer setting the scene for a seismic shift in elderly hospitalisation numbers, which at the start of the NHS in 1948 were “miniscule.”<sup>612</sup> “People aged 60 or over make up nearly a quarter of Britain’s population, and half of those aged over 60 years have at least one chronic illness...an increasing number of patients are older and frail and around 25% of inpatients have a diagnosis of dementia.”<sup>613</sup>

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<sup>611</sup> The Kings Fund (2014) – *Making our health and care systems fit for an ageing population*- D.Oliver,C.Foot and R.Humphries- Introduction Page 1.

<sup>612</sup> Royal College of Physicians of London Report, September 2012: Hospitals on the edge? The time for action, ‘*Changing patients, changing needs*,’ p.3.

<sup>613</sup> Sourced from [www.ipsos.mori](http://www.ipsos.mori) on 3 September 2012.

The chapter begins by looking at the requirements of transparency and accountability<sup>614</sup> that the elderly require if there is to be safe care and that the patient is to be the centre of care delivery. This is followed by discussion of the rights of the elderly and their progression in some leading cases. Finally, there are some conclusions that suggest the Care Act 2014 is taking elderly care in an appropriate new direction that resonates with the initial idea of Professor Sir Ian Kennedy to make the patient at the heart of the system of elderly care. Many of the key organisations such as Age UK are generally supportive.<sup>615</sup>

#### 8.1 Accountability and Transparency: Making elderly care patient led

The NHS Constitution under the Health Act 2009, requires health bodies, including the Care Quality Commission (CQC), to take account of the following requirements as to rights and expectations of all patients as follows:

*“The NHS provides a comprehensive service, available to all irrespective of race, gender, disability, age, sexual orientation or belief. It has a duty to each and every individual that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population.”*

Increasingly elderly care in medical terms is seen as a specialist subject, geriatrics. In the context of continuously expanding numbers of elderly, issues of

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<sup>614</sup> ‘Accountability’ is defined on Page 13 of Chapter 1 of this thesis and ‘Transparency’ is defined on the following Page 14.

<sup>615</sup> AGE UK Sutton See the Care Act 2014: A Briefing.

greater complexity arise. These include life expectancy, NHS social care funding, and long term medical conditions. All these matters need to be addressed if the NHS is to fulfil its full expectations for the elderly. The Francis Report also emphasises the need for robust systems of transparency.

One aspect of transparency and accountability is the increasing role of medical litigation and insurance claims. Undoubtedly, such cases drive forward changes in the delivery system including proper paperwork and the careful monitoring of patients while under hospital care. In private homes, there is also the need for robust systems of tracking and ensuring that medication is undertaken carefully.

In this context whilst private law actions for negligence have grown public law judicial regulatory oversight of local authorities, the NHS and other public bodies involved in elderly and other care provision have been constrained in terms of access to judicial review and its success rate. These are mostly procedural oversight of financial resource allocation.

*“There are also legal aid cuts and changes in costs as well as the procedures for judicial review that may erode the potential of worthy claimants to go to court...Judicial reticence raises questions and uncertainties about the role of the law and lawyers at a time of greatest need for redress.”<sup>616</sup>*

*“Thus, in the economic and financial sphere the effects of the crisis and associated cuts are still emerging...In the human rights sector, the future is equally of concern in that, in the light of recent Government curtailment of access to judicial review against public authorities for various purposes*

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<sup>616</sup> *Human Rights and Social Rights in the UK: The Post-Financial Crisis and the Reform of the Welfare State and Social Economic Rights.* (December 2013) - Professor John McEldowney (University of Warwick). See: *R v Leonard Cheshire Foundation (A Charity)* [2002] 2 All ER 936 C.A.

*including human rights, the effect of spending cuts will clearly engage so much in policy at local and national level that the willingness of the judiciary to develop judicial review into “policy” territory from which it has historically resiled remains to be seen and the effect on human rights...could be extremely considerable.’<sup>617</sup>*

Upholding of the rule of law as such is therefore at the heart of these emerging issues. In the context of current and future severe austerity measures by government, negligence litigation’s expansion with few means of control other than improved training would represent an unwelcome resource surprise. Earlier the figures for clinical negligence pay-outs for the NHS in England alone £3.9 Billion was cited for the financial year 2000-01,<sup>618</sup> and recently the National Health Service Litigation Authority made a public statement that the claims pay-out figure for 2012-13 had climbed steadily since those times to 10,129 claims paying out £1,258 Billion, having climbed 11% in one year alone to 11,945 claims, which figures exclude other NHS litigation and exclude defence costs paid out to panel solicitors defending the claims.<sup>619</sup>

These are understood to be broadly reflective of levels of negligence litigation in the private care home sector, thus impacting on negligence insurance premiums in the private sector and there the already reduced resource receipts from local authority cuts.<sup>620</sup> These facts are serious issues for ongoing financial sustainability in both the NHS and private care and nursing home sectors.

Financial accounting is often a useful evaluative tool and this may help monitor the quality of standards for long term costs and outcomes. There is a

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<sup>617</sup> John McEldowney *ibid*.

<sup>618</sup> National Audit Office- *Adult social care in England: an overview* - (11.March.2014) HC 1102 – [www.nao.org.uk](http://www.nao.org.uk)

<sup>619</sup> NHS Clinical Assessment Service (26 February 2014) via Catherine Dixon Chief Executive of the National Health Service Litigation Authority – [www.nhs.uk/currentactivity/Documents](http://www.nhs.uk/currentactivity/Documents).

<sup>620</sup> [www.laingbuisson.co.uk/reports](http://www.laingbuisson.co.uk/reports).

continuing need to ensure that financial and audit systems are effective. The National Audit Office (NAO) report in March 2014, the first in a series on adult care, warns that local authority expenditure for adults in three years since 2010 had fallen by 8% in real terms for its contribution to individual packages of adult care services for home care, care home care and day care. For older adults the effect was 12%, and in many areas only critical needs were being local authority supported.

NHS hospital acute and chronic care services had been government ‘ringed-fenced’ but not the 10% or so contribution they had been making to non NHS places of care. The NAO also warned that health care is poorly managed,<sup>621</sup> finding that specifically adults do not transfer between health and social care in a timely and efficient manner, and safeguarding vulnerable elderly and other adults from abuse and neglect remained a major concern.

It is clear that tensions have emerged between social service provision and the budget allocation given to local authorities. Budget cuts have driven deeply into the availability of funds even for the disabled. In the High Court judicial review case *R(D) v Worcestershire County Council* (2013),<sup>622</sup> Worcestershire County Council had adopted a policy that the available resources to disabled persons living in their own homes would not exceed meeting the same person’s needs in residential care. The financial principles under which this policy operated came from the resource allocation system (RAS)....Government have introduced an automatic 10% cut...Over time this policy was applied to older people, and all new service users and those currently receiving community based services. The Court found that the Council, as

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<sup>621</sup> NAO Report (11 March 2014) – *ibid*.

<sup>622</sup> [2013] EWHC 2490 – this first instance decision based upon an alleged failure of a local authority not to discriminate against a disabled minor under Section 149(1) of the Equality Act 2010 (2010, c.15), and alleged breach of his Article 5 European Convention right (deprivation of liberty and right to security of the person) concluded that in following statutory policy formulation procedures the local authority had acted correctly.

statutory policy decision maker, had correctly addressed all the criteria procedurally that was required of it.

## 8.2 Accountability under the Care Act 2014

Recently, the Government have taken steps to improve accountability systems through the Care Act 2014. By 1 October 2014, the new fundamental standards of care centred around individual need embracing nine criteria to meet 'well-being',<sup>623</sup> plus the statutory duty of candour, proposed by Robert Francis, together with a 'fit and proper' persons test for individual board members of NHS and other health statutory decision makers.<sup>624</sup> Thus accountability will focus on individuals as well as organisations.

By April 2015, there will be a right to information and advice, accessible explanations for financial advice and also an increased role for local authorities to (m)provide access to information that will enable better, more independent, financial advisers. One striking innovation in the Act is to give explicit recognition to the rights of carers. Finally there is an attempt to set a cap on care costs.<sup>625</sup>

## 8.3 The Care Quality Commission and its inspections regime

A recent report from the King's Fund has evaluated the role of inspections offered by the Care Quality Commission.<sup>626</sup> These are "more rigorous and wide-ranging" than in the past. The CQC has recruited a new level of professional

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<sup>623</sup> Implementing Paragraph 10 of the Law Commission Report – *Adult Social Care*- (May 2011) presented to Parliament – HC941.

<sup>624</sup> Respectively Sections 1 and 9, 81 and 53 of the Care Act 2014 (2014, c.23).

<sup>625</sup> Respectively Sections 4, 10 and 15 – Care Act – *ibid*.

<sup>626</sup> Katy Steward, *Exploring CQC's well-led domain* The King's Fund, 2014



expertise to undertake inspections. This is directed at Boards of NHS Trusts as well as managers and management systems within hospitals.

Consistent with this is the build up to, and implementation of, a change on 1<sup>st</sup> October 2014 to specialist inspections in place of the generic regime. Inspectors now specialise in a particular care sector of which they have knowledge and experience, use data information acquired beforehand, and issue reports using clinical judgement not compliance.<sup>627</sup>

#### 8.4 Human rights and the elderly

The Human Rights Act 1998 is also relevant to elderly patient care. Its importance is emphasised in the Care Act 2014<sup>628</sup> which provides for anyone receiving funded or publicly arranged care are protected whether or not in a private or public home. Such protection is not directly available if the entire care is self-funded or privately arranged.<sup>629</sup>

The application of the Human Rights Act to private care homes proved controversial and more complicated than had been expected. As will be seen, political extensions of the State in terms of the 'reach' of Convention rights took place by statute in 2008 and 2014, but the Human Rights Acts cases considered fall into two broad categories, namely those, such as YL, which challenge care home

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<sup>627</sup> Care Quality Commission – Annual Report to Parliament – (July 2014) HC295 – Foreward – Pages 6-7.

<sup>628</sup> (2014, c.23) Section 73 of which extends Convention rights against a public body to places giving regulated care or support where any component of that funding is publically provided. This extends to a wider scope of care provision the original intention of the 2008 Parliament which reversed the effect of the majority judgement of the House of Lords in YL v. Birmingham City Council, by Section 145 of the Health and Social Care Act 2008 2008, c.14).

<sup>629</sup> [www.legislation.gov.uk/ukpga/2014/23](http://www.legislation.gov.uk/ukpga/2014/23). (When fully implemented in due course.) Section 9 will make residential care one of many options that service providers are able to fund. Eligibility will accordingly shift from the current entitlement based on need to one of criteria based on financial considerations. This represents a major shift in care provision and one for which many policy considerations need to be taken into account. Evaluating the full cost of options is also difficult but necessary.

cuts and closures and those such as McDonald which challenge cuts in care delivery.

In *YL v Birmingham City Council*,<sup>630</sup> an Alzheimer's patient was excluded from a care home run by a private company, Southern Cross Healthcare Ltd (Southern Cross). Birmingham City Council had a statutory duty under Sections 21 and 26 of the National Assistance Act 1948<sup>631</sup> to make arrangements for her residential care but had decided to contract that to Southern Cross. Southern Cross decided to end the contract with YL, without giving her any opportunity to appeal or to give her family any opportunity to make out a case for her continued residence in the care home.

Judicial review was sought by her for relief under the Human Rights Act 1998 specifically the right to Articles 2 (right to life), 3 (right not to be subjected to torture or degrading treatment or punishment) and 8 (right to respect for private and family life, home and correspondence) of the European Convention on Human Rights. The majority of the House of Lords rejected YL's claim on the basis that the care provider was a private company, and did not engage the "functions of a public nature" definition in Section 6(3)(b) of the 1998 Act, which the 1998 Parliament had intended should not make a blanket extension of human rights to the private sector, following the Court of Appeal, in *R (Heather) v Leonard Cheshire Foundation*,<sup>632</sup> where the Court had found in the case of the *Leonard Cheshire Foundation* that it was not a public body within the meaning of Section 6 of the Human Rights Act 1998 for the purposes of judicial review, and that the case of *Aston Cantlow and Wilmcote with*

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<sup>630</sup> [2007] UKHL 27.- a judgement subsequently reversed by statute.

<sup>631</sup> (11 & 12 Geo.6, c.29).

<sup>632</sup> [2002] EWCA Civ 366.

*Billesley Parochial Church Council v Wallbank*,<sup>633</sup> the House of Lords in that instance, had given wide expression to the “public function” in Section 6 (3)(b) of the 1998 Act but with the same outcome that Southern Cross was a private body. Hence Article 8 Convention rights (right to home and family life) were not engaged.

The dissenting decisions of Lord Bingham and Lady Hale found that the statutory regime could be discharged by either a public or private provider, being the apparent intention of the 1998 Parliament, and human rights followed that obligation.

The resultant discussion was wide ranging including criticism of the judgement. The analysis ranged widely over the elderly and their expectations raised by rights and their protection, with elderly care delivery being spread across both public and private sectors.

The Equality and Human Rights Commission’s perception of its own statutory function resulted in it issuing a far-reaching report in November 2011 with some controversial issues raised in it:<sup>634</sup>

#### 8.4.1 Gaps in the coverage of the Human Rights Act

In 2000, when the HRA came into effect, many more older people using social care would have had human rights protection. At this time, 44 per cent of care was provided directly by local authorities and 56 per cent by private and third sector providers.<sup>635</sup> But in 2000 the role of private sector bodies and care homes was thought to be excluded from the Human Rights Act.

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<sup>633</sup> [2003] UK HL 37.

<sup>634</sup> *Close to home* – ‘An inquiry into older people and human rights in home care’ – (23 November 2011) – [www.equalityhumanrights.com/homecareinquiry](http://www.equalityhumanrights.com/homecareinquiry) - Executive Summary; but the issue of improving human rights protection was revisited by a very late House of Lords amendment to the Bill by Earl Howe, Health Minister and is now revisited in Section 73 of the Care Act 2014.

<sup>635</sup> Sourced from – Laing and Buisson (2011) *Domiciliary Care UK Market Report 2011*. London: Laing and Buisson. Table 2.4.

The human rights protection of home care users has also been weakened by the decision of the Supreme Court in the case of McDonald.<sup>636</sup> By a majority, the court decided that it was lawful for the local authority, given its limited resources, to withdraw Ms McDonald's night-time care.

#### 8.4.2 Our key conclusions

The majority of older people using home care services lack the protection of the HRA, and that the 'reversal' of the judgement in *YL v Birmingham city* in Section 145 of the Health and Social Care Act 2008 had left an unsatisfactory statutory gap for the majority of care home users (as well as people paying for their own home care).<sup>637</sup>

There is a lack of investment in care workers, influenced by commissioning practice and the workforce being predominantly female and part time, leading to low pay and status, in sharp contrast to the level of responsibility and skills required to provide quality home care."<sup>638</sup>

The EHRC official sequel to its November 2011 Report, after further consultation and enquiry on its part, arose in May 2013 in the form of 38 pages of its considered statutory guidance to local authorities and others involved in the commissioning of elderly care delivery who are within the scope of the Human Rights Act 1998.<sup>639</sup>

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<sup>636</sup> *R (McDonald) v Royal Borough of Kensington and Chelsea* [2011] UKSC 33-(discussed in more detail later in this chapter) but this EHRC finding is actually a misinterpretation of the majority Supreme Court judgement which (per Lord Brown) turns on the application of domestic legislation correctly by a local authority needing to save £22,000 per annum on this lady in the face of national funding cuts. The Court finds that in terms of Strasbourg jurisprudence Article 8 is not transgressed by the margin of appreciation available to a member state for its domestic legislation. But not mentioned is also the very significant case of *YL v Birmingham City Council* [2007] UKHL 2007.

<sup>637</sup> *Close to home* – Report *ibid* – page 90.

<sup>638</sup> *Close to home* – Report *Ibid.* – pages 95 and 96.

<sup>639</sup> *Guidance on human rights for commissioners of home care* – Equality and Human Rights Commission (May 2013) – [www.equalityhumanrights.com/guidance](http://www.equalityhumanrights.com/guidance) - stated to have been compiled "in collaboration with the

The outcome was that after all party political support, Parliament enacted section 145 of the Health and Social Care Act 2008<sup>640</sup> which extended the Human Rights Act to private care homes.

In “*R(D) v Worcestershire County Council* (2013)<sup>641</sup> the court, considered an application for judicial review on behalf of a minor with multiple disabilities challenging policy formulation and implementation which would lead to the reduction of financial support for the applicants home based social care, and potentially force him into residential care. The policy formulation challenge was based upon a statutory and case law base, including Section 149 issues with the Equality Act 2010. It was held that the Council’s consultation process in determining its policy was lawful in manner and substance, including its right to take into account its own finance loss as a factor. By analogy, elderly care is also affected by such a ruling.

Case law regarding elderly care also includes the leading decision on legitimate expectation in *Coughlan*.<sup>642</sup> Although also not specifically a case of elderly care, as it involved a woman of fairly youngish years who was severely disabled in a road traffic accident, being promised by the NHS that her final move into an NHS nursing home would be “home for life,” established through the courts the firm recognition of a right to substantive legitimate expectation in circumstances where the NHS tried to move her on was described by the court as “an abuse of power” by a public body and was blocked by the court. The use of this for potentially elderly care cases is dependent upon the individual circumstances in which any

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Association of Directors of Adult Social Services (ADASS), (i.e., the local government heads of social services departments) and others (Page 3).

<sup>640</sup> (2008, c.14).

<sup>641</sup> [2013] EWHC 2490 (Admin.)- Hickinbottom,J.

<sup>642</sup> *R v North and East Devon Health Authority (ex parte Pamela Coughlan)* [1999] EWCA Civ 1871.

commitment is made by a public body. The Statutory right and duty of the NHS to use its expert judgement to make resource allocation was unusually overridden here.

In *Turner*, the joint applicants here endeavoured to seek via the court the setting aside of local authority decisions to close a care home and, in that connection, their applications failed both in the High Court and the Court of Appeal.<sup>643</sup> In particular, the Court of Appeal having checked that the appropriate procedural grounds had been carefully addressed by the local authority, found that the local authority had complied with Section 6 of the Human Rights Act 1998<sup>644</sup> and, in particular, they had acted in a matter comparable with Articles 2, 3 and 8 of the Convention.<sup>645</sup>

In particular, the Court criticised the “recent proliferation of publicly funded litigation designed to prevent the closure of local authority care homes or to render implementation of closure impracticable.”<sup>646</sup> The same judge stated that “we direct that this judgment be communicated to the Legal Services Commission;...there has to be concern at the drain on public funds on both sides...so long as councils do the best that can professionally be done to minimise identifiable risks to frail and elderly people in their care, the law has no immediate role to play.”

In *Watts*, in adjudicating upon the application of a 107 year old lady (in 2010) who was a resident at a Wolverhampton City Council care home, Underhill House, which the Council intended and planned to close. The Council gave evidence in

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<sup>643</sup> *Turner v Southampton City Council* [2009] EWCA Civ 1290- A judgement considered by the European Court of Human Rights in *Watts v United Kingdom* [2010] ECHR 793- below..

<sup>644</sup> (1998, c.42).

<sup>645</sup> In summary:

Article 2 - “Everyone’s right to life shall be protected by law.”

Article 3 - “No-one shall be subjected to torture or to inhuman or degrading treatment or punishment.”

Article 8 - “Everyone has the right to respect for his private and family life, his home and his correspondence.”  
European Convention on Human Rights.

<sup>646</sup> *Turner Ibid.* – Sedley, L. J.

judicial review proceedings against it that the current operation of the home was at a cost of 50% per resident higher than equivalent private sector care homes, that its duty to deliver cost effective care and safety could not be met by improvement expenditure, and that it had carefully engaged the complex sensitivities of moving Mrs. Watts to a nearby alternative home.

The Strasbourg Court agreed with the judgement of the Court of Appeal, and were referred to a number of UK court judgements, including Turner, where local authorities were engaged with financial and other resource management issues. Mrs. Watts was refused relief.

The Court looked at all three Human Rights Act limbs of her claim as follows:<sup>647</sup>

#### Article 8

*The applicant complains of an interference with her private and family life as a result of the involuntary transfer. She also complains of a lack of respect for her physical and psychological integrity.*

*The Court considers the transfer in the present case to be proportionate and justified under Article 8 of the Convention. The applicant's complaints under Article 8 must therefore be declared inadmissible...*

#### Article 6

*The applicant complained that she did not have access to a court in respect of the decision to close Underhill House and transfer her to a new home and relied on Article 6, which provides in so far as relevant "In the determination of his civil rights and obligations ...everyone is entitled to a fair...hearing...by [a] tribunal". The Court noted that she had been refused judicial review in the*

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<sup>647</sup> Watts v the United Kingdom – 53586/09 [2010] ECHR 793.

*High Court and on appeal to the Court of Appeal and accordingly found that this head of complaint is “manifestly ill-founded and rejected in accordance with Article 35 of the Convention”.*

#### Article 14

*The applicant complained of the alleged discriminatory treatment of disabled residents in accordance with Article 14 (discrimination). “The Court finds no appearance of a violation of the rights and freedoms set out in the Convention or its Protocols arising from this complaint. The complaint must therefore be declared inadmissible...”*

#### Conclusion

*For these reasons, the Court unanimously declares the application inadmissible.*<sup>648</sup>

In the leading case of *McDonald*<sup>649</sup> (*Appellant*) v *Royal Borough of Kensington and Chelsea* (*Respondents*) [2011] UKSC 33:<sup>650</sup> the question of the form of elderly care delivery available at night time for a patient in need of care support was considered:

*...whether the Respondent Royal Borough acted unlawfully in seeking to amend the Appellant’s care package by substituting her night-time carer with provision of incontinence pads or absorbent sheets (hereafter “pads”) when the Appellant is not in fact incontinent.*

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<sup>648</sup> *Ibid.*

<sup>649</sup> *R (McDonald) v Royal Borough of Kensington and Chelsea* [2011] UKSC 33 – The Equality and Human Rights Commission expressed disapproval of this judgement in its report *Close to Home – An inquiry into older people and human rights in home care* – (23 November 2011) [www.equalityhumanrights.com/homecareinquiry](http://www.equalityhumanrights.com/homecareinquiry) – page 90/91.

<sup>650</sup> [2010] EWCA Civ 1109.



*In September 1999, the Appellant, Ms McDonald, suffered a stroke leaving her with severely limited mobility. She also suffers from a small and neurogenic bladder...having to urinate some two or three times in the night. Up to now, she has dealt with this by accessing a commode with the help of a carer provided by the Respondent... In November 2008, however, the Respondent proposed instead that the appellant should use pads, avoiding the need for a night-time carer and thereby providing her with greater safety (preventing the risk of injury whilst she is assisted to the commode), independence and privacy and in addition reducing the cost of her care by some £22,000 per annum.*

By majority, the Supreme Court decided that it was lawful for the local authority, given its limited resources to withdraw Miss McDonald's night-time care, and no breach of her rights under Article 8 (Right to Respect for Private Life)<sup>651</sup> in the context of a series of UK Parliamentary statutes setting out her entitlement.

The Court took the view that even if this decision had interfered with her Article 8 rights, the interference was proportionate and justified within the range of options available to the local authority in terms of addressing policy resource allocation, and accordingly within a member state's 'margin of appreciation', being upheld in June 2014 by the European Court of Human Rights on the basis that there was an Article 8 interference but in the circumstances it was justified.<sup>652</sup>

There are a number of cases where the courts have been asked to consider the economics of homes closing. The reluctance of the courts to become involved in

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<sup>651</sup> A "qualified" right subject to the circumstances and unlike an "absolute" right such as Article 3 (torture or inhuman or degrading treatment). So it thereby invokes the member state's "margin of appreciation".

<sup>652</sup> McDonald v United Kingdom (Application No. 4241/12) (13 June 2014).

reviewing the case for closure of a home arose in ‘D’ and ‘S.’<sup>653</sup> The two claimants were both disabled elderly people who wished to prevent a local authority closing a home on the basis:

*It is unlawful because it was taken without due regard to the disability equality duty in section 49A of the Disability Discrimination Act 1995 [(1995, c.50)]; the defendant’s ongoing consultation on its ‘Revised Social Care Offer’ breaches the common law duty of fairness...and the consultation was further flawed because of the defendant’s alleged non-compliance with the single equality duty in section 149 of the Equality Act 2010.*<sup>654</sup>

In his judgment, the Judge looked carefully at all the procedural steps carefully taken by the defendant council,<sup>655</sup> in accordance with its statutory duties of policy implementation,<sup>656</sup> and accordingly rejected the Applicant’s case.

In Davis, the claimants owned two care homes and applied to the court to quash decisions made by the Defendant council which they said were made in breach of the rules of natural justice, government guidance, the Defendant’s own policies and a legitimate expectation.<sup>657</sup> The Court considered the Council’s statutory duties under section 47(1) of the National Health Service and Community Care Act 1990,<sup>658</sup> Section 21(1) of the National Assistance Act 1948,<sup>659</sup> Section 29(1) of the 1948 Act and Section 45(1) of the Health Services and Public Health Act 1968.<sup>660</sup>

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<sup>653</sup> *The Queen (on the application of ‘D’ and ‘S’) and Manchester City Council* [2012] EWHC 17 (Admin).

<sup>654</sup> (2010, c15).

<sup>655</sup> Ryder, J (sitting at the Manchester Administrative Court).

<sup>656</sup> The long established judicial principle in judicial review proceedings being for a court not to substitute itself for the policy decision maker determined by parliament – see, for example, *YL v Birmingham City Council* [2007] UKHL 27, and *(R) McDonald v Royal Borough of Kensington & Chelsea* [2001] UKSC 33, and a long line of earlier case law.

<sup>657</sup> *Davis v West Sussex County Council* [2012] EWHC 2152 (QB).

<sup>658</sup> (1990, c.19).

<sup>659</sup> (1948 (11 & 12 Geo.6, c.29)).

<sup>660</sup> (1968, c.46).

The Judge criticised the defendant authority for the decisions having not been reached fairly and there had been no recognition by the defendant that it had acted in any respect unjustly or inappropriately,<sup>661</sup> and...“some of the evidence put forward by the Defendant...shows an apparent inability to recognise...some basic requirements of fairness. In these circumstances a quashing order is necessary...”<sup>662</sup>

The above case reviews display that in relation to local authority home closures, those specific human rights issues appear in a sense to have “settled down” at European Court level as well as Court of Appeal and High Court levels, in terms of balancing respective interests and proportionality for the qualified convention rights in issue.

## 8.5 Elderly care homes – human rights

Human rights issues within the care home sector present a totally different picture, particularly in respect of Article 8 (respect for private and family life) and Article 14 (discrimination against elderly or disabled elderly people).

Abuse ‘behind closed doors’ is widespread,<sup>663</sup> but belies the good care homes evident as well, and recently triggered even resort to camera use being approved in principle by the CQC recently. In its ongoing “Care in Crisis” campaign, the charity Age UK continues to identify a multiplicity of shortcomings with elderly care delivery across the care home sector. This includes personal dignity issues.<sup>664</sup>

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<sup>661</sup> His Honour Judge McKay QC (sitting as a Deputy High Court Judge in London).

<sup>662</sup> Davis *Ibid*.

<sup>663</sup> A BBC Panorama programme – *Behind Closed Doors: Elderly Care Exposed* (May 2014) secretly filmed neglect by care home staff of elderly persons, verbal abuse and physical violence against people who were frail and vulnerable – Discussed in Guardian Interview with Andrea Sutcliffe, Chief Inspector of adult social care at the Care Quality Commission – [www.theguardian.com/commentisfree/2014/may/05](http://www.theguardian.com/commentisfree/2014/may/05).

<sup>664</sup> [www.ageuk.org.uk/get-involved/campaign/care-in-crisis](http://www.ageuk.org.uk/get-involved/campaign/care-in-crisis).

Example evidence are Parliamentary statements from ministers from time to time,<sup>665</sup> frequent newspaper reports and local authority statistics showing English local authorities having investigated 35,810 allegations of abuse in care homes.<sup>666</sup>

## 8.6 Ombudsman accountability

Individual elderly people who have unfair or poor service complaints against government departments or the NHS in England have possible recourse to the Parliamentary and Health Service Ombudsman. Statutory criteria require that their issues are without any alternative legal remedy such as a civil or criminal right of action or judicial review.<sup>667</sup>

Wide powers of investigation of that public body's file and interview and written explanations are available to that Ombudsman, including the right, if applicable, to require a remedy or other rectification of its conduct. That official has developed liaison relationships with regulators such as the CQC, professional bodies such as the General Medical Council regulating doctors, and the Local Government Ombudsman, and reports back to Parliament.<sup>668</sup>

The elderly persons' component of the Ombudsman's jurisdiction however, seems lower than it could be, because in April 2014 the Ombudsman, Dame Julie

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<sup>665</sup> Norman Lamb, Minister of State for Care and Support, Department of Health since September 2012 pledged to "stamp out" widespread care home abuse of the elderly – House of Commons (1 May 2014) – [www.bbc.co.uk/democracylive](http://www.bbc.co.uk/democracylive).

<sup>666</sup> Some of these local authority investigations lead directly to criminal prosecutions. – For example- *Care workers found guilty of abusing dementia patients 'for laughs'*- Preston Crown Court (November 2013) – 3 care workers convicted after a 4 week trial by jury – The Guardian (28 November 2013)- [www.theguardian.com/society/2013/nov/28](http://www.theguardian.com/society/2013/nov/28). Another, random, example is *Essex care home worker arrested on suspicion of assaulting elderly resident* – "A woman has been arrested on suspicion of assaulting a resident at a care home...The owner company has sacked 7 members of staff"- (3 May 2014) The Guardian- [www.theguardian.com/society/2014/may/03](http://www.theguardian.com/society/2014/may/03).

<sup>667</sup> Parliamentary Commissioner Act 1967 (1967, c.13) and the Health Service Commissioners Act 1993 (1993, c.46).

<sup>668</sup> Latest version is *The Ombudsman's Annual Report and Accounts 2013-14- A voice for change*- (18 July 2014) HC 536 – which refers to having investigated 2199 complaints in its year across its jurisdiction upholding 854 of those.

Mellor, made a press statement that many elderly had a culture of not wishing to complain about the NHS.<sup>669</sup> In the absence of an ombudsman or spokesperson for the elderly in the private care home sector one can only speculate about the situation there.

## 8.7 Conclusions

Elderly care is an increasingly important concern for families and relatives. The Francis report has created a new culture for more rigorous standards and for wide-ranging investigations into how care is delivered. Well managed care homes are a result of good regulatory inspections, culturally put patients at the heart of care management and are effective in the delivery, and overarching need, for clearly established accountability and oversight systems.

We have seen how the various regulatory bodies have developed a specific role. The Care Quality Commission has introduced new tougher inspections. The CQC annual report and subsequent evaluation by the National Audit Office provides an important oversight over the CQC and its practices. However, whilst incremental improvement has been achieved as a result, 'regulatory gaps' such as those identified in the Francis Report persist, and the financial costs of the intensified CQC activity have yet to be seen, and to meet public, user and Parliamentary satisfaction.<sup>670</sup> Those financial issues are one thing, but the apparently 'out of control' costs of negligence litigation is entirely another. At some point soon that crisis alone will need to be addressed in terms of affordability. It has certainly demonstrated accountability.

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<sup>669</sup> *Older people in NHS care suffering in silence, says health service ombudsman* (7 April 2014) The Guardian – James Meikle - [www.theguardian.com](http://www.theguardian.com).

<sup>670</sup> A political exercise of seeking short term results at the expense of a future (post-May 2015 General Election) Parliament counting the financial cost may be at work here, including regard being had for the NAO's 'after the event' auditory function.

In public law accountability terms, we have also seen that the courts have an important, but often limited role to play. The highest profile cases of Watts (2010) and McDonald (2014) have been considered in more detail because they recently reviewed other case law. Increasingly their role is to consider the limits of spending cuts and the proportionate and reasonable delivery of health care. This trend is likely to continue, even though the courts are limited to legality issues, it is clear that policy considerations underpin many of their decisions.

The statutory 'extension' of human rights protection across the private care home industry has so far had an unsatisfactory outcome in care improvement terms. At the heart of this is probably the Ombudsman's cultural finding on the NHS side of care delivery, namely that many elderly "suffer in silence" and don't want to raise issues with those they have to face daily, even in the private care sector.

This paints a very serious picture of the extent to which mistreatment of the vulnerable elderly in the private care sector has yet to emerge, and how regulatory systems alone even if they engage devices such as whistle-blowing and cameras, each of these demonstrably problematic, can defeat these care delivery abuses.

Elderly care in care homes is nevertheless likely to continue in a trend that reflects growth in the elderly population. This should not overlook the fact that in the UK many elderly are cared for in their own homes by family, relatives and friends. Also, any abuse in that latter care sector is largely unmonitored.

## CHAPTER 9: Case studies of Elderly Care: Medical and Related Challenges

### 9.0 Introduction

Selecting some specific case studies of elderly care is intended to show the variety and types of elderly care that are currently available. This has been possible from assistance from Age UK and the aim is to show how varied and complicated elderly care has become. This sets a clear challenge for regulation but equally it is indicative of the rapidly changing roles of care homes in Britain today.

The case studies are largely from interviews, notes and conversations with a wide variety of elderly care providers. Very significant in their absence from this study are many potential contributions from front line care organisations and individuals who flatly refused even anonymous interviews arising from possible litigation fears or confidentiality issues.

The chapter begins with an outline of the assortment of challenges facing the elderly today followed by a discussion of the main interviews.

### 9.1 Elderly care: The medical and related challenges

Elderly care is undergoing major changes in both its delivery and perceptions about its quality as well as expectations raised about what may be achieved. The King's Fund report on *Making our health and care systems fit for an ageing population*<sup>671</sup> suggests that pressures on the NHS have resulted in a policy shift:

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<sup>671</sup> David Oliver, Catherine Foot and Richard Humphries, *Making our health and care systems fit for an ageing population* The King' Fund London, (2013).

*We must strive to shift the curve from high-cost, reactive and bed-based care to care that is preventive, proactive and based closer to people's homes, focusing as much on wellness as on responding to illness*<sup>672</sup>.

It is clear that this ambition will take time to put into practice. The King's Fund have found major inequalities "in both absolute life expectancy and healthy life expectancy at 65 and in rates of premature death before 75." There are variables in the uptake of various vaccinations and prevention strategies including pneumococcal vaccinations.

The Royal College of Physicians Report on elderly care notes that:

*"care in our hospitals is undergoing considerable change. Nearly two thirds (65%) of people are over 65 years old (and) occupy more than 51,000 acute care beds at any one time, accounting for 70% of bed days...People over 85 years old account for 25% of bed days – increased from 22% over the past 10 years...People over 85 tend to spend around eight days longer in hospital than those under 65."*<sup>673</sup>

The potential complexities of care delivery to an elderly couple at home with the pseudonyms of 'Malcolm and Barbara' suffering from varying degrees of Alzheimer's disease are well illustrated diagrammatically below.<sup>674</sup>

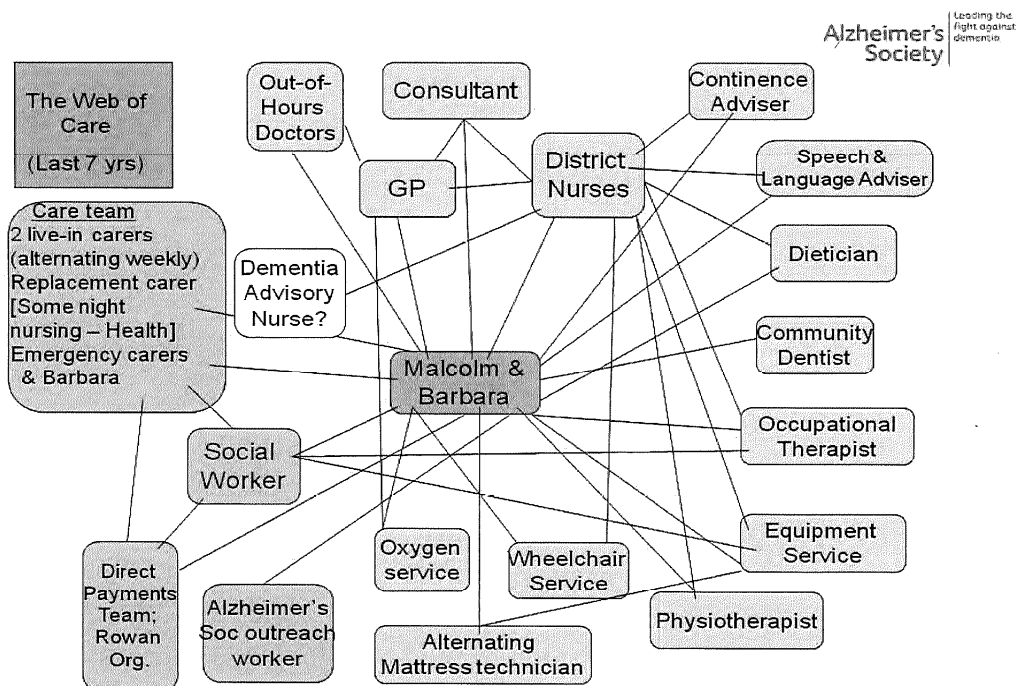
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<sup>672</sup> *Ibid.*, p. 3.

<sup>673</sup> RCP report *Ibid.*

<sup>674</sup> Part of a paper presented to the thesis writer by National Voices (People Shaping Health and Social Care) (below) at a Birmingham conference on Co-ordinated Care – (26 March 2013) -[www.publicserviceevents.co.uk](http://www.publicserviceevents.co.uk).





A typical case study would present the less demented wife supporting the more demented husband, or both of the couple requiring care, or, if fortunate, a family member or friend or neighbour, have to co-ordinate these service suppliers, and also these latter people do not necessarily know each other nor receive a properly informed account of the specific need. In the example, the need for the wife to continuously repeat her story to each professional clearly demonstrated the need to develop a transferable care plan, so that she only needed to tell her story once.

Co-ordination of care delivery at hospital level calls for separate analysis and consideration but at least there the success or failure of such does involve professional staff. Arguably the issues at national level are well identified as being unsatisfactory fragmented care delivery in many reports, and in particular on the

Government side of activities by the House of Commons Health Committee,<sup>675</sup> the House of Lords Select Committee on Public Service and Demographic Change<sup>676</sup> and by the Department of Health itself.<sup>677</sup> Other advocates are the National Audit Office,<sup>678</sup> and Government sponsored pilot schemes in different parts of the country,<sup>679</sup> and the independent charity National Voices.<sup>680</sup> Other bodies in what has become a strong debate on these issues include charities such as the Nuffield Trust, Age UK, the King's Fund and others.

## 9.2 Elderly care: multiple conditions

Recent research has illustrated that people accumulate long term conditions, and also that, by the age of 65, most people have also accumulated multiple conditions, as the graph/diagram below illustrates.<sup>681</sup>

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<sup>675</sup> On 8 February 2013 – 'Health Committee report on Social Care calls for joined up commissioning. [www.parliament.uk](http://www.parliament.uk) following up on its Fourteenth Report into social care (HC Fourteenth Report of Session 2010-12).

<sup>676</sup> *Ready for Ageing?* (14 March 2014) HL Paper 140 – Paragraph 52.

<sup>677</sup> *Integrated Care and Support: Our Shared Commitment* - (13 May 2013), [www.dh.gov.uk](http://www.dh.gov.uk).

<sup>678</sup> Report by the Comptroller and Auditor General – (HC 1040 Session 2010-12) – *Case study on integration: Measuring the costs and benefits of Whole-Place Community Budgets*. Department for Communities and Local Government.

<sup>679</sup> For example the Inner North West London Integrated Care Pilot set up in 2011 and continuing – referred to in a Nuffield Trust report – (17 May 2013) – *Evaluation of the first year of the Inner North West London Integrated Care Pilot*. [www.nuffieldtrust.org.uk/integration](http://www.nuffieldtrust.org.uk/integration). A second example (of 16 in all) is the one involving Staffordshire County Council Social Services Department known as the Staffordshire and Stoke on Trent Partnership NHS Trust – [www.staffordshireandstoke-on-trent.nhs.uk](http://www.staffordshireandstoke-on-trent.nhs.uk), but the 'veteran' is the Torbay and Southern Devon Health and Care NHS Trust on which work started in Brixham, Devon, in 2004 – [www.torbaycaretrust.nhs.uk](http://www.torbaycaretrust.nhs.uk) but the predecessor statutory body came into existence as a trust on 1 October 2000 [www.torbaycaretrust.nhs.uk/about/us](http://www.torbaycaretrust.nhs.uk/about/us).

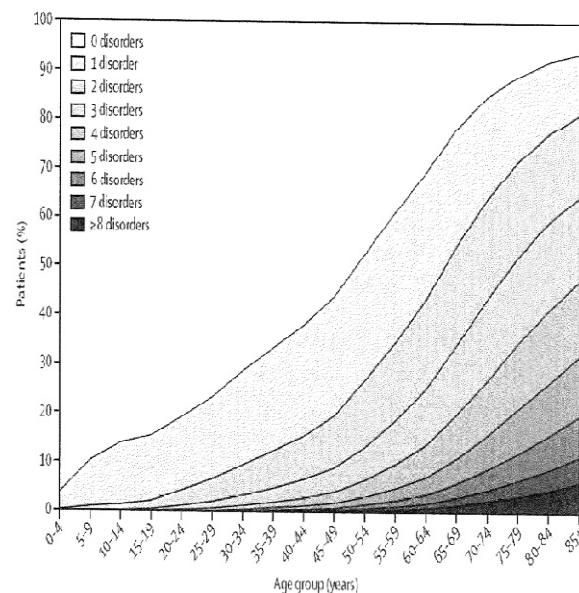
<sup>680</sup> A registered charity in receipt of some government funding, formed as a company limited by guarantee in 2009 to help deal with the problem, and whose members consist of an enormous range of private, charitable, medical and interested organisations on a national level with central London headquarters.- [www.nationalvoices.org.uk](http://www.nationalvoices.org.uk)

<sup>681</sup> A study by Karen Barnett and others – *Epidemiology of morbidity and implications for health care, research, and medical education: a cross-sectional study* – (10 May 2012) - The Lancet – [www.press.thelancet.com/morbidity](http://www.press.thelancet.com/morbidity)

# Increasing number of multi morbidities

People accumulate long term conditions as they age

By 65, most people have multiple conditions



*Barnet et al: Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study (2012)*

Arguably, therefore, even at domiciliary delivery of care level in the context of one condition alone, Alzheimer's, the clear challenges for current and future care delivery co-ordination are self-evident.

The interaction of these complexities with the need to deliver such care at hospitals, hospices, nursing homes and residential care homes accordingly begins to form a picture, not only in the context of availability of resources, encompassing a large spectrum including personnel, medicine, equipment, etc. - and not least financial resourcing of supply, but also in relation to co-ordination of delivery of such resources.

In the context of attempts to improve co-ordination of care delivery currently, it seems clear that the ongoing Torbay Trust trial project has been running for well over a decade, engaging additional responsibilities and functions across the care delivery spectrum in its geographical area. Torbay Borough Council social services interacted with it in December 2005 when it gained responsibility for both commissioning/buying and providing integrated health care and social services, and from 1<sup>st</sup> April 2011 gained the statutory power to be responsible for community health care services in south Devon.<sup>682</sup>

Arguably the Torbay pilot would supply a 'joined up' care delivery template for the rest of geographical England, and perhaps Wales, but further analysis of pilots elsewhere seem not to meet that expectation in common template terms, and indeed seem to question such integration elsewhere in England.

Thus, the Inner North West London Integrated Care Pilot established in September 2011, did not seek to engage with all care delivery in the first instance, but targeted two key groups of people: people with diabetes, and those over 75 years of age. The Nuffield Trust who monitored its progress came up with some interim findings in May 2013.<sup>683</sup> The findings were that it was clearly very 'early days' in the context of which the pilot has undertaken, with a pooling of "information...using an IT tool which allows for the identification of patients needing intensive case management...This evaluation covered the pilot's first year of operation (between September 2011 and July 2012)." It was, however, largely inconclusive.

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<sup>682</sup> *Ibid.* – [www.torbaycaretrust.nhs.uk/aboutus](http://www.torbaycaretrust.nhs.uk/aboutus) (history of the trust) - which also states that the trust "works with a range of local voluntary sector organisations, and with several NHS providers and local authorities".

<sup>683</sup> Report of 17 May 2013 *Ibid.* – the full report being at [www.nuffieldtrust.org.uk/publicationsd/evaluation-nw-london-icp](http://www.nuffieldtrust.org.uk/publicationsd/evaluation-nw-london-icp).

One of the few measurable outcomes was a marked increase in diagnoses of dementia.<sup>684</sup> Although the Staffordshire and Stoke-on-Trent Partnership NHS Trust pilot commenced activity on the same day,<sup>685</sup> an analysis of much more detail was made available on 26 March 2013.<sup>686</sup> The presenter reported that each party to the joint venture pilot was “challenged” by each having to acclimatise to the culture of the other and amidst a collision between the quite different bureaucracies of the different organisations. Also that “there was still a strong culture of numbers of people to be processed which had far to go to reach a person- centred approach.”

Further findings were:

1. *The need to move staff across to the new trust body from their existing employment arrangements encountered resistance and objection from the participators and legal advisers in respect of TUPE<sup>687</sup>, pension transfer complications, payroll and other issues to be resolved; the NHS and local authorities had quite different staff benefits and related controls;*
2. *Collision of culture issues arose from one district to another, let alone the whole county of Staffordshire;*
3. *Adding another body to the care delivery system did itself complicate many things to date in the pilot;*
4. *Care professionals clearly benefitted from much more contact with each other according to their own feedback;*

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<sup>684</sup> Report *Ibid.* – Summary.

<sup>685</sup> [www.staffordshireandstokeontrent.nhs.uk/governancedocuments/annualreport2011-12](http://www.staffordshireandstokeontrent.nhs.uk/governancedocuments/annualreport2011-12).

<sup>686</sup> By Ian Benson its Authorised Supervising Officer, Staffordshire County Council, at the Conference on Co-ordinated Care, Birmingham.

<sup>687</sup> The Transfer of Undertakings (Protection of Employment) Regulations 2006 (SI 2006/246) regulating rights and liabilities of the various parties in keeping intact the employees contractual position thereby triggering automatic potential friction with new colleagues on different pay and terms and conditions when doing the same work.

5. *Amidst all of these challenges, the further frustration was that any degree of success was usually not capable of measurement for the purposes of motivating those involved.*<sup>688</sup>

The practical and legal complexities of which care delivery business model to develop for the future of the Staffordshire pilot are illustrated by the following three sets of analyses, which arguably demonstrate the enormity of the task,<sup>689</sup> and thus illustrate one of the most intractable elderly care delivery issues identified by the thesis.

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<sup>688</sup> Ian Benson *Ibid.*

<sup>689</sup> Ian Benson *Ibid.*

## WHY WAS FULL INTEGRATION CHOSEN? (1)

Organisational model	Ownership	Pros	Cons	Conclusion
Council – internal service redesign	Public sector	<ul style="list-style-type: none"> <li>• Council has flexibility and control</li> <li>• No cultural barriers to service change – potential for innovation at service level</li> <li>• Connection between demand and supply is immediate and transparent</li> </ul>	<ul style="list-style-type: none"> <li>• Delivery and policy interwoven</li> <li>• Constrained business model</li> <li>• Social care and health economy is working</li> <li>• Service user pathways are complex/ fragmented</li> <li>• Opportunities for innovation and efficiency are limited to organisational boundary</li> </ul>	Shortlist: Appraise as “do nothing” Option A – Continue as we are
Establish and transfer services to agency/ arm's length body	Public sector	<ul style="list-style-type: none"> <li>• First stage in separation of delivery from policy</li> <li>• Can have quasi commercial objectives (e.g. financial performance)</li> <li>• Develop customer/supplier relationship</li> <li>• Limited freedoms available</li> </ul>	<ul style="list-style-type: none"> <li>• No change/improvement in stakeholder relationships with NHS/ service users</li> <li>• Creation of new management structures, set up costs - no clear mechanism for efficiencies</li> <li>• Increases health and social care service fragmentation rather than reducing it</li> </ul>	Do not pursue

## WHY WAS FULL INTEGRATION CHOSEN? (2)

Organisational model	Ownership	Pros	Cons	Conclusion
Joint appointment: NHS and local authority have some key joint appointments and the teams collaborate but are not integrated or combined.	Public sector	<ul style="list-style-type: none"> <li>• Some reduction in hand-offs</li> <li>• Potential for shared vision/ understanding between health and social care for local area</li> </ul>	<ul style="list-style-type: none"> <li>• Collaboration and good practice in some areas but lack of consistency across all social care services</li> <li>• Organisational barriers remain</li> <li>• Potential for cross health and social care innovation – but change is slow as two sets of governance structures</li> <li>• Duplicated management costs and corporate functions</li> </ul>	Shortlist: Appraise as Option B – "Greater Joint Working with the NHS" option
Establish and transfer services to Local Authority Trading Company	Public sector	<ul style="list-style-type: none"> <li>• Commercially based</li> <li>• Manage transition between inefficiency and being competitive</li> <li>• Can trade itself</li> <li>• Independent existence under law or statute.</li> <li>• Company limited by shares</li> <li>• LA "ownership" can be retained via directorships on Board</li> <li>• Significant council influence</li> <li>• Company limited by shares or guarantee under Company Law or Statute (often termed public sector corporations or statutory corporations).</li> <li>• Much greater autonomy within delegated</li> </ul>	<ul style="list-style-type: none"> <li>• Contractually based relationship</li> <li>• Ability to take on health functions</li> <li>• No change/improvement in stakeholder relationships with NHS/ service users</li> <li>• Creation of new management structures, set up costs - no clear mechanism for efficiencies</li> <li>• Increases health and social care service fragmentation rather than reducing it</li> <li>• Separate legal entity – new organisational boundary. Barrier to pace of change and innovation.</li> <li>• Potential VAT and corporation tax issues</li> </ul>	Do not pursue



## WHY WAS FULL INTEGRATION CHOSEN? (3)

Organisational model	Ownership	Pros	Cons	Conclusion
Full integration: Trust and local authority form a combined service	Public sector	<ul style="list-style-type: none"> <li>• Full integration is consistent with the values, aims and objectives of both partner organisations</li> <li>• Opportunities removes organisational boundary – improved opportunities for innovation / efficiency and pace of that change</li> <li>• Transfer to new Trust increases financial critical mass and will improve financial viability</li> <li>• Business driven</li> <li>• Commercially aware</li> </ul>	<ul style="list-style-type: none"> <li>• Requires cultural change management as staff transition from Council to NHS leadership</li> <li>• Potential VAT issues</li> <li>• Pensions issues</li> <li>• NHS Trust is a new organisation - due diligence must evidence financially stable</li> </ul>	Shortlist: Appraise as Option C - "Full Integration" option
Establish/ transfer services to public interest company/ social enterprise	Third sector	<ul style="list-style-type: none"> <li>• Mission, members and shareholders may include public sector legacy relationships and mentality – could be an innovative organisation that is aligned to Council social care strategy.</li> <li>• Appropriate model for entities/services with high perceived public interest role (like social care)</li> </ul>	<ul style="list-style-type: none"> <li>• Evidence suggests success is often reliant upon process being management driven – appetite may not be there in Council</li> <li>• Regulatory requirements – CIC, FSA</li> <li>• Pensions transfer issues</li> <li>• VAT issues</li> <li>• Technically outside public sector – potential staff/ union engagement issues</li> <li>• Increases health and social care service fragmentation rather than reducing it</li> <li>• Separate legal entity – new organisational boundary. Barrier to pace of change and innovation.</li> </ul>	Do not pursue

There are a number of specific issues that are relevant to the elderly and these may be outlined below.

### 9.2.1 Life Expectancy

Life expectancy projections for the period up to 2032 by the Office for National Statistics in November 2011, contain some very noteworthy warning relating to long term care (LTC) and expenditure related to it as well as relating to pensions.<sup>690</sup>

*If life expectancy rises in line with the high life expectancy variant then by 2032 Government would need to find an additional 0.2 per cent of GDP to finance the pensions system and an additional 0.1 per cent GDP to finance the LTC system. The effect of improvements in life expectancy on pensions and LTC expenditure taken together provides a starker picture ... of state expenditure, projected to rise from 5.6 per cent GDP in 2007 to 7.8 per cent of GDP by 2032 under the principal life expectancy assumption. The assumptions about GDP that we are using are likely to be optimistic since they pre-date the financial crisis.*<sup>691</sup>

### 9.2.2 NHS Social Care Funding 2021/2022

As recently as July 2012, research by the influential Nuffield Trust with the Institute for Fiscal Studies looked at the issues related to this topic, including its implicit effect on the future of elderly care delivery:<sup>692</sup>

*Public spending on the UK NHS has increased faster than economy-wide inflation since the 1950s, with an average real growth rate of 4.0 per cent a year between 1949/50 and 2010/11 (when spending reached £137.4 billion).*

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<sup>690</sup> Health Statistics Quarterly – The effect of lengthening Life Expectancy on future pension and Long-Term Care expenditure in England, 2007 to 2032 (22 November 2011) - Juliette Malley (LSE).

<sup>691</sup> *Ibid.*

<sup>692</sup> *NHS and social care funding: the outlook to 2021/22* (July 2012) Nuffield Trust and Institute for Fiscal Studies Research Report (Rowena Crawford and Carl Emmerson).

*This is significantly greater than growth in the economy over this period. Spending (funded by higher taxation) increased particularly rapidly under the last Labour Government.*

Estimates of overall costs are hard to predict accurately.<sup>693</sup>

*If total spending is held constant as a share of national income thereafter then, in the absence of further welfare cuts, spending on public services could only be expected to grow by an average of 1.1 per cent a year in real terms over the seven-year period from 2015/16 to 2021/22. Given the relative protection<sup>694</sup> afforded to health spending over the period of 2010/11 to 2014/15 such an increase would come at a cost to other public services...Increases in NHS productivity are, therefore, desperately needed but notoriously hard to find and deliver...Serious thought would...include reconsidering the range of services available free of charge<sup>695</sup> to the whole population or the level of taxation needed to finance those services in the future.<sup>696</sup>*

*In fiscal terms, on the basis that all NHS expenditure relating to hospital care for the elderly is based on fiscal funding with some other elderly care services being based partly on fiscal funding and partly on private resources, an authoritative review was carried out in July 2013 in respect of this issue,*

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<sup>693</sup> The Declared 2010 “ring-fencing” policy of the coalition government to protect health expenditure from the general “cull” of public spending.

<sup>694</sup> The declared 2010 “ring-fencing” policy of the Coalition Government to protect health expenditure from the general ‘cull’ of public spending – [www.gov.uk/government/publications/the-coalition-documentation](http://www.gov.uk/government/publications/the-coalition-documentation) (20 May 2010).

<sup>695</sup> Compared, for example, with the NHS dentists patient charging system.

<sup>696</sup> Compare, for example, with the NHS dentists patient charging system.

*including National Debt projections to the 2060s.<sup>697</sup> On the question of demographics we are told that:*

*As spending on long-term care is heavily skewed towards the elderly, it rises as a share of GDP as the population ages. It is not only the rate of ageing that is important, but also the prevalence of disability at different ages. Life expectancy with a care need at age 65 more than doubles over the next 50 years, and at a much faster rate than overall life expectancy. Spending on long-term care is projected to rise from 1.3 per cent of GDP in 2017-18 to 2.4 per cent of GDP in 2062-63.*

### 9.2.3 NHS handling of long-term medical conditions

What can be identified as a potential “dislocation” of long term care is identified, particularly given that the elderly have more long term medical conditions than the younger population. The NHS faces increasing demands on its services. In a recent interview with one of the directors of NHS England was reported in *The Guardian* and contains somewhat an urgent message for the need for reform very quickly.<sup>698</sup>

*15.4 million people in England with at least one long-term condition already takes up 70% of the NHS's £110bn budget - £77bn – as well as £109bn of the £15.5bn spent on social care in England. The costs are so huge that the NHS could become unsustainable unless it gives those with long-term conditions better care, with much of it provided by GPs performing enhanced roles rather than hospital doctors.*

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<sup>697</sup> Fiscal sustainability report (July 2013) Office for Budget Responsibility - [www.obr.gov.uk](http://www.obr.gov.uk).

<sup>698</sup> NHS could be ‘overwhelmed’ by people with long-term medical conditions (3 January 2014) *The Guardian* – Denis Campbell, health correspondent. Interview with Dr Martin McShane, NHS England’s Director for Enhancing the Quality of Life for People with Long Term Conditions.

McShane<sup>699</sup> is responsible for those ongoing illnesses or diseases that see patients become regular users of NHS services. They include arthritis, heart disease, breathing problems, obesity and mental health conditions such as depression. Their numbers have risen dramatically in recent years, largely as a result of the ageing population. McShane states:

*The NHS in its current form is not well set up to look after patients who are medically complicated...People with multiple long-term conditions often fall through the gaps as their secondary [hospital] care is highly specialised and their GP care highly generalised, with little continuum between the two, meaning .... fragmented secondary care.*

*Too many are not getting proper care and can end up having largely avoidable spells in hospital.... Professor Andrew Street, a health economist at York University, has found that while a healthy patient costs the NHS about £288 a year, those with one long-term condition cost an estimated £738, those with two cost £1,521 and those with three cost £2,559 each.*<sup>700</sup>

McShane wants some family doctors to do extra training and become “complex care GPs,” to look after only people with long-term conditions, especially the 5% of the population who are the heaviest users of NHS services and take up most of the doctors’ and nurses’ time.”<sup>701</sup>

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<sup>699</sup> Dr. Martin McShane *ibid*) – NHS England Director.

<sup>700</sup> McShane – *ibid*.

<sup>701</sup> *Ibid*.

#### 9.2.4 Challenges to traditional perceptions of “dependency” and economic criteria

Traditional economic criteria used to drive Government policy rests on the question of how a person is defined as a ‘dependant.’ Michael Hill is concerned about incorrect assumptions being made:<sup>702</sup> “To obtain a balanced picture of the impact of societal ageing on social policy, there is a need to examine the process of demographic change and its relationship to economic policy rather carefully before going on to look at its direct impact on social policy.”<sup>703</sup>

The exploration of issues about dependency used in the demographic predictions employ age as the defining variable. However, if it is defined instead in terms of labour market participation, the picture may be very different.

*(On) the so-called rising burden of elderly populations. The discussion of pensions suggested that private pensions are ‘assets’ that involve claims on current production when they are cashed. This is not the case with housing wealth. Inasmuch as they own fully paid-for housing, people take a pre-funded asset into their elderly years. They may realise this asset if they ‘trade down’ to cheaper smaller accommodation or take advantage of marketed equity release schemes. They may be forced to realise the asset by means-tests. Or they may pass on the asset to the next generation. In all cases they are reducing the burden on the next generation in ways that have been given very little attention in discussions...of so-called dependency.*

How should the “aged” be treated? The question has many aspects.

*“It is important to recognise that it is the pattern of labour market participation rather than the demographic profile in each country that needs*

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<sup>702</sup> *Social Policy in the Modern World – A Comparative Text* (2006) Michael Hill – Blackwell Publishing: Oxford – Chapter 12 “Ageing Societies”.

<sup>703</sup> *Ibid* p.247.

*primary attention. Furthermore, even use of this more accurate index of dependency can lead us into economistic thinking where only people who are economically active are perceived as making contributions to society.*<sup>704</sup>

The whole concept of “reliance” implied in the term “dependency” used by economists who drive political policy is therefore open to question.

#### 9.2.5 The ongoing effect of the financial crisis and medical litigation

The effects of the banking crisis into Government policy delivery and associated financial constraints is illustrated by Professor McEldowney<sup>705</sup> giving rise to serious concerns about the future of care delivery in the public and private sectors, and associated human rights issues. He identifies the following:

*“The UK is running a budget deficit set in 2011/12 to be £576 billion with government spending forecast to be £703 billion. Primarily the budget deficit is financed through the sale of government bonds.”*<sup>706</sup>

Budget cuts make it difficult to evaluate the Government’s promise to ring fence the NHS budget. Inflation of care costs is an example of the political dimension to the debt and financial crisis. A fine dividing line has to be drawn between the needs of the most vulnerable and the public spending required for their support.

In 2010 KPMG, the international accountancy firm, made clear that the underlying motive was not only to cut public spending but also to change the main mode of delivery from public to private provider and this is likely to have far reaching significance.

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<sup>704</sup> Michael Hill –*Ibid* – p.249.

<sup>705</sup> *Human Rights and Social Rights in the UK: The Post-Financial Crisis and the Reform of the Welfare State and Social Economic Rights*. (December 2013) - Professor John McEldowney (University of Warwick).

<sup>706</sup> McEldowney – *ibid*.Page 5.

*The presenting issue is about levels of spending, but the real issues are about shifting control from providers to their customers and from bureaucrats to enterprising professionals. This is the only way we can enable people to get what they need from public services, albeit for less.*<sup>707</sup>

### 9.3 The case studies of elderly care

The case studies outlined below consist of selected examples and interviews of experiences of elderly care.

#### 9.3.1 Southern Cross Healthcare Group – A Case Study

The Southern Cross Healthcare Group PLC case recently came into high profile publicity as a result of its financial difficulties. Emphasis must be made, in this particular case study, that it is a highly selective view of one part of what may be termed ‘private sector’ healthcare provision, and as such (particularly from visits to other private sector homes for the purposes of this study) is known to be a ‘worst-case’ scenario in a very wide spectrum of private care-provision activity.

Also involved is that a commonly recognised corporate structure (which the writer has long experienced and continues to experience in private legal practice) is to separate ongoing business risk of potential failure or insolvency from valuable business assets, is to place the freehold properties or other valuable business assets<sup>708</sup> into a holding company which owns the shares in the legally separate

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<sup>707</sup> *Payment for Success – How to shift power from Whitehall to public service customers* London: KPMG, 2010, page 2. Alan Downey, Paul Kirby and Neil Shirlock.

<sup>708</sup> Anything from intellectual property to plant and machinery, for example.



corporate entity, the trading company, which carries the day to day risk of economic and financial failure.<sup>709</sup>

Southern Cross was a care home business and its freehold assets were in common ownership prior to 2006, it appears from reports that such a separation was established into two separate private legal entities, but, contrary to the holding and trading company common principle, the trading company was then launched into public shareholder ownership.<sup>710</sup> Its Stock Exchange floatation in July 2006 based its income and projected expansion, with a rising market in terms of the growing ageing population, on a sale of its many freehold premises with a leaseback to the operating company. This business model had many of the leases having an inbuilt 2.5%, or thereabouts, annual rent increase and high dependency on continuity of the then level of local authority financial support for many of its residents.<sup>711</sup>

By the time one of the Southern Cross Group of Companies, Southern Cross Healthcare Limited, came before the judicial body of the House of Lords on 30 April 2007,<sup>712</sup> Southern Cross was providing the residential care which Birmingham Council was obliged to offer to persons with an entitlement under Section 21 of the National Assistance Act 1948,<sup>713</sup> it was providing 29,000 resident residential care places across the country of which the Court was told 80% were Section 21 placements funded wholly by local authorities. That is an interesting statistic at that

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<sup>709</sup> Banks and landlords typically protect themselves by directors personal guarantees and cross-guarantees (inter-company).

<sup>710</sup> For example, The Guardian 18 June 2011 (Richard Wachman) and 29 July 2011 (Rory Coonan).

<sup>711</sup> Case studies show this to be a common profitability level across the care home sector.

<sup>712</sup> *YL v Birmingham City Council and others* [2007] UK HL 27. The action was by a resident suffering from dementia, who was endeavouring to establish that her Article 6 rights under the European Convention (right to a home and family life) were being breached by her attempted removal from the care home but a majority of the House of Lords found that care delivered by a private company for a local authority was not Article 6 protected then. This was amended by statute later.

<sup>713</sup> (1948, 11 & 12 Geo.6, c.29).

point which is apparently typical across the growth of the private sector care delivery.<sup>714</sup>

By 2011, the 2008 property market slump had taken hold with local authorities implementing financial cutbacks, including in particular elderly care support.<sup>715</sup> In addition, councils were caring for more people in their own homes so that by the time Southern Cross took them on and they had a greater proportion of cases of dementia, immobility and incontinence than before costing Southern Cross more when their revenues were declining. CQC intervention became frequent with statutory 'improvement' notices affecting nearly 30% of their 750 homes with some 31,000 residents.

Significantly, in the same Report, is a statement by Peter Hay, President of the Association of Directors of Adult Social Services that:

*Private companies have inserted £19 billion of investment in the last 20 years. You would never have got that from the public sector. Also, standards are getting higher. In 1991, I remember a local authority home where there were six men to a bedroom and 12 sharing a bathroom. These days having your own room and facilities is becoming the norm.*

Formal insolvency of Southern Cross was deferred by many public and private officials engaging in talks and negotiations, one outcome being Barclays Bank and Lloyds Bank respectively writing off its debts to them of £30M and £20M<sup>716</sup> after ministerial pressure to do so.

The economic pressures, therefore, on such care home company directors, who are commonly shareholders themselves, are culturally in place to maximise

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<sup>714</sup> See [www.laingbuisson.co.uk/reports](http://www.laingbuisson.co.uk/reports).

<sup>715</sup> The Guardian 16 July 2011 (Richard Wachman).

<sup>716</sup> The Guardian 2 December 2011 (Richard Wachman).

such dividends by various means, including minimum compliance with the standards of the regulator. Far from Southern Cross being a “one-off” crisis there is research evidence that there are many care home companies suffering from funding cuts by local authorities’ own cutbacks. In an early 2013 sample of 4,872 UK care home companies, almost one third were shown to be at ‘an above average risk of financial failure.’<sup>717</sup> This objective material alone casts a serious shadow over a large part of the elderly care industry.

The respective regulators in the health-care delivery sector therefore have to enforce the same standards across a large variety of business models including private individual proprietors or small or larger partnerships individual proprietors or small or larger partnerships (including limited liability partnerships) and further analysis shows a wide spectrum of success and failure.

### 9.3.2 (a) The CQC and the Morecambe Bay report

On 19 June 2013 arguably one the greatest challenges to face the CQC upon publication of its Independent report into its registration and oversight of University Hospitals Morecambe Bay Foundation Trust (UHMB), the independent component being the business consultancy firm Grant Thornton who named the investigation and overview by them as “Project Ambrose.”<sup>718</sup>

The background to these events involved multiple maternity deaths which the CQC decided not to investigate in 2009 followed by CQC’s decision in April 2010 to permit Monitor to register UHMB as a Foundation Trust without conditions.

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<sup>717</sup> This research eventually emerged as a 25 August 2013 report by Company Watch a market researcher – [www.companywatch.net](http://www.companywatch.net).

<sup>718</sup> Their report being dated 14 June 2013 and located at [www.cqc.org.uk/media/cqc-publishes-independent-report-its-registration-and-oversight-of-university-hospitals-morecambe-bay-nhs-foundation-trust](http://www.cqc.org.uk/media/cqc-publishes-independent-report-its-registration-and-oversight-of-university-hospitals-morecambe-bay-nhs-foundation-trust). (19 June 2013).

Thereafter, upon being appointed Chief Executive of the CQC in July 2012, David Behan commissioned the Grant Thornton review. This background was discussed in the House of Commons on 19 June 2013 when Jeremy Hunt, the Health Secretary, made his statement to the House about the findings.<sup>719</sup>

Under the heading “Key Findings” Grant Thornton states:

*...we have identified aspects of poor governance at CQC...as well as questionable decision making by the Regulator.... We also have concerns about the apparent failure...to share information with CQC, which would have enabled CQC to make more informed decisions. This particular issue has...implications for the subsequent authorisation by Monitor of Foundation Trust status to UHMB, as we understand Monitor, in part, relied upon care quality information provided to it by CQC.*<sup>720</sup>

*We did find evidence of the apparently deliberate suppression of an internal CQC report entitled ‘Summary of the internal review of the regulatory decisions and activity at UHMB’, which was commissioned by senior management at CQC in October 2011...and was critical of CQC’s regulatory oversight at UHMB.....The report...may constitute a broader and on-going cover up.*<sup>721</sup>

The Grant Thornton report then goes on to conclude under the heading “Regulatory Oversight” that:

*Our overall view is that CQC will consider that there were a number of failures in its regulatory oversight of UHMB, both centrally and regionally, during the period*

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<sup>719</sup> Hansard (Commons) 19 June 2013 Columns 923 – 936.

<sup>720</sup> UHMB report *Ibid.* – para 1.15.

<sup>721</sup> UHMB report *Ibid.* – para. 1.17. See Julia Black (2013), “blurring of edges” issue on regulatory accountability.

*under review, certain of which...should have been recognised at the time. We noted:*

- *weaknesses in governance around systems and procedures to assure the quality, accountability and proper management of CQC's operations;*
- *a lack of transparency around why certain decisions were made or changed; and ultimately*
- *an apparent decision in March 2012 to delete the internal report referred to above, on the quality of CQC's regulatory oversight at UHMB, which had identified and summarised many of these same issues.*<sup>722</sup>

How far into the NHS this culture permeates is a matter of conjecture. Some data construction driven by a statistical culture prevails perhaps over a quality of care culture. There is always the lurking doubt that the few bad examples, largely found out by chance, represent much larger numbers of NHS trusts in reality.

Politicians will, it seems, continue to engage in a 'fire-fighting' exercise from one crisis to the next in the NHS, and care delivery in particular, but the obvious presence of fundamental flaws in the regulatory system itself rather than just lack of finance in a financial crisis leaves many questions unanswered.

#### (b) The Cavendish Review

In the wake of the above report came an independent Government-sponsored review by a journalist, Camilla Cavendish, into current issues affecting healthcare assistants and support workers in the NHS and social care settings.<sup>723</sup>

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<sup>722</sup> UHMB report *Ibid.* – para 1.21.

<sup>723</sup> The Cavendish Review (10 July 2013) - [www.gov.uk/review-of-healthcare-assistants-and-support-workers](http://www.gov.uk/review-of-healthcare-assistants-and-support-workers).

Broadly her findings were that this very diverse body of largely essential workers in the care delivery industry felt largely undervalued and/or underpaid and many lacked appropriate skills acquisition recognition. Broadly accepted by Government were her recommendations of better recognition, training and career progression opportunities.

Her more specific findings get to the heart and core of elderly care delivery, and its successes and shortcomings. These include her view that many organisations care staff turnover rates are so high, and pay so low and often without travel cost and time being reimbursed, that these forces work against health and social care integration. Bridging that division, and between assistants and qualified nurses, will reduce costly duplication, create a more effective work force and necessarily elevate the status of caring.

Intense investigation by her for this report across the nation also revealed the great dedication of some to and fierce advocacy for those they cared for, in homes and elsewhere. Looking after the frail with intelligent kindness has become more complex as staff often have to undertake specialised tasks, such as invasive procedures, which used to be the preserve of district nurses.

She found that the best organisations recognise the value of their workforce, recruit them for their commitment to caring and patient safety, and ensure that rigorous training and development translate into daily practice. In that process, old post-war practices has moved into the modern reality of chronic conditions amongst those they care for. Health Education England is one of the significant outcome

results in official acceptance of this Report.<sup>724</sup> Adequacy of future funding then becomes the ongoing challenge.

(c) A case study of a regulator turned regulatee

A lady (“MC”) interviewed for the purpose of this study, being a continuing Registered General Nurse (RGN) (formerly State Registered Nurse (SRN) in her case) and a continuing joint proprietor of a well-known nursing home in Leamington Spa, Warwickshire, had much to offer the study from her experience of the system back to her originally qualifying as an SRN in 1962. She continues to be engaged in the management and joint ownership together with a married couple in this particular elderly care delivery sector in Leamington Spa and the delivery of the care is run for the purposes of the business via a private limited company.

The couple have management experience and business experience generally but do not have the healthcare qualifications that MC possesses. Nevertheless, although being a minority shareholder in the Company (10% of the shareholding) and joint proprietor of the premises, she nevertheless is in a position where she is largely manipulated by the male of the married couple so much so that she has little information about how the business is being run.

According to her and the thesis writer’s checks on the statutory register for this Company at Companies House, the private limited company involved is a typical nursing home and rest home proprietor (one of each type of home in the case of this

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<sup>724</sup> Care Act 2014 (2014, c.23) established by Section 98. Section 99 then makes provision for the planning, education and training for healthcare workers, and Section 98 addresses the issue of ensuring that there are sufficient skilled healthcare workers for the health service.

Company) and each year only needs to file 'abbreviated accounts'<sup>725</sup> to fulfil its corporate statutory obligation, being a Company with a turnover of under £6.5M.<sup>726</sup>

In MC's experience of the month to month running of the nursing home, any inspections by the CQC which have taken place in recent times could easily be deflected in terms of establishing whether any particular level of care is really taking place due to the template used by CQC inspectors. To put matters into context, her particular background was engaged between 1960 and 1962 in the required training and qualification for State Registered Nurse and this was mostly at Warwick Hospital, having added to earlier experience.

From 1985 to 1986, she was part of a nursing home inspection team then run by the NHS in co-operation with Social Services of Warwickshire County Council, who then had the statutory remit to inspect care homes. The inspection team processed applications for continuing registration from existing nursing homes and those from new homes. The nursing home practises quickly got dated in those times and the demand for my training was, therefore, very considerable in terms of bringing them up to date. She operated and oversaw a very successful training programme which visibly improved care standards and care delivery.

Although the Regulated Homes Act 1984 in her view did visibly improve the regulatory system for residential care homes and nursing homes because the rules had 'more teeth,' each NHS health authority regulating the nursing home side would do things 'their way' and there was a considerable inconsistency in standards from one authority to another in terms of what was required of the nursing home staff and management in each case. Nevertheless, the inspection criteria was more geared to

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<sup>725</sup> Except to HM Revenue and Customs for taxation purposes only.

<sup>726</sup> Listed under the heading of "Small Companies: Conditions for exemption from audit in the Companies Act 2006 (2006, c.46) – Section 477(2) (b)".



the quality of premises and room size and equipment provision than the standards of care themselves.

During these years, she remained in the nursing home ownership and management system, having been the proprietor of Catherine House, Leamington Spa nursing home from 1990 to 2003. Social Services funding, as a component of the management of patient care, became more and more difficult and, to keep herself in profit, to get private patients to subsidise the Social Services funded patients were essential.

When the Healthcare Commission (the Commission for Healthcare Audit and Inspection) (HCC) took over regulating this type of care in April 2004, they still didn't achieve a way of measuring 'care' as such. The building and facilities were still their focus so some places got "full marks" if they "ticked the right boxes", as I believe is still now the system with the CQC as far as my own experience is concerned. During these years the increase in paperwork required by the HCC and its predecessor became quite horrendous for nursing home owners and managers. The view was adhered to by her professional judgement was best, but the inspectors still demanded the processes be carried out their way.

In 2003, she went to what was then the City College Coventry and taught from then until 2012 (part time) on Health and Social Care to NVQ Level 3. In her view, teaching this qualification was a very positive step forward to bring healthcare aspiring people up to the appropriate standard but she was conscious that existing qualified nursing staff and medical staff resisted this qualification for the wrong reasons.

She has continuously been involved in elderly care for the last three decades directly (especially dementia) and is conscious that in other homes demented people

get a bad deal because they are kept sedated to keep them quiet. As a continuing manager/proprietor of a nursing home since 2009 when the Care Quality Commission took over as regulator, she has met them on several occasions but take the view that they were just engaged in a 'tick box' exercise and are not, in any way, 'measuring care' as such.

She has been a member of the Royal College of Nursing (RCN) for many years and remains as a member. Once the modern system of general management got into hospitals in the last decade or so in place of qualified nursing officers, they got heavily into statistics, and involved, in her view, in great manipulation of statistics – she has personally witnessed manipulation of statistics at a local hospital where she continues to be involved). Managers are good at this kind of management but it is not surprising to me that the figures were being manipulated in the Stafford Hospital crisis.

Personal experience of the Warwickshire County Council Social Services Department is also that there is a cultural issue including the great reluctance on their part to share data with persons such as nursing staff in hospitals or proprietors of nursing homes.

As far as the recent regulatory system is concerned, the CQC have simply used the wrong sort of people with insufficient intelligence doing the job and, if there is not a radical overhaul, then the regulatory system on their part was then simply not going to work properly in terms of overseeing healthcare, and is purely mechanical.

In terms of the change in the role of nurses since she came into the elderly care system, she takes the view that hospital nurses are spending far too much time writing reports rather than with patients. There has been a significant deterioration in this respect since the 1990s, and its effect on healthcare delivery is very obvious in

terms of quality and patient experience. My overview is that since the 1980's era of nursing home inspection, which I personally experienced, the CQC still do not have a means of measuring 'care' and this is just one of many criteria. Overall she thinks that the 1984 Regulated Homes Act was a move in the right direction but 'joined up' care is still seriously challenging the potential for positive change for the future.<sup>727</sup>

#### 9.4 A recent family experience

Two daughters interviewed for the purpose of this thesis who placed their Mother (M), in a residential care home in eastern Coventry which could cater for persons with dementia, found that the management systems in place there actually brought about their Mother not having at least one-third of her Tamoxifen treatment because she was asleep at the appointed hour of delivery of that drug, resulting in it exacerbating her breast cancer. When they lodged a formal complaint, it became clear that those who would normally administer the drug found they had not got the authority to override the time schedule, which had been specified for its administration to M and the GP had to be engaged in a revision process. Nevertheless, when their Mother died in July 2013 at the home, they found that the staff were "absolutely wonderful" and "could not do enough for the family at the moment of crisis" and proved themselves to be an extremely caring team of people.

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<sup>727</sup> A view endorsed by the House of Lords Select Committee on Public Service and Demographic Change in its Report – *Ready for Ageing?* (14 March 2013) HL Paper 140 – Paragraph 52.

#### 9.4.1 Case example from a senior nurse

A senior graduate nurse from the Nuffield private hospital system<sup>728</sup> described her personal experience of handling CQC inspections for her employers in 2011 and 2012. In each case the two CQC inspectors involved seemed to be using an NHS hospital inspection model not appropriate for the private sector, and they neither were well versed in the audit criteria nor able to offer other than a 'tick-box' format which offered no latitude on the criteria offered.<sup>729</sup>

On each visit the inspector's lack of any specialist training and experience was evident, including specialties such as geriatric, but on the latest visit did seem more focussed and wanted to take a 'fly on the wall' role choosing which staff and patients they wanted to speak with so as to endeavour to understand the culture on each area of care.<sup>730</sup> She considered that the last CQC visit to her hospital<sup>731</sup> being unannounced captured a more accurate inspection picture than the previously announced visit<sup>732</sup> but the resultant CQC scoring system made it more difficult for an outsider to judge the extent of any failure compared with the previous HCC scoring system, which made failures more easily identifiable, and overall the continuity by the CQC of generic inspection models seemed to her then to be completely inappropriate.<sup>733</sup>

Appearing to recognise the deficiency in this process the Health Secretary has indicated recently a change of policy to the effect that the CQC "has committed

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<sup>728</sup> Interviewed on 5 February 2013 for the purposes of this study.

<sup>729</sup> For example: protective bed-rail user in a single private patient room differs from appropriateness of user in an NHS open hospital ward.

<sup>730</sup> "In particular we would encourage the CQC to require its inspectors to ask themselves about the culture of care within an organisation" Commons Health Committee (Report 9 January 2013 – *Ibid.* Para. 31.

<sup>731</sup> During late 2012.

<sup>732</sup> For which purposes equipment had been "borrowed in".

<sup>733</sup> An opinion mirrored for the care home sector in the evidence of the R&RA to the Commons Health Committee (Report 9 January 2013, *Ibid.*); and the same report at conclusion no. 10 added – "The Committee welcomes the greater use and availability of clinical expertise to support the work of inspectors. We note, however, that 87% of inspections carried out since this resource became available did not use it".

to bring an end to the days of generalist inspectors...From this year, new and thorough expert-led inspections will get to the heart of how hospitals are serving their patients...”<sup>734</sup> In another part of this report,<sup>735</sup> reference is made to ‘the over-representation of international medical graduates in the fitness to practice process. The research showed that qualifying outside of the UK and being male means that there is a greater likelihood of fitness to practice concerns being raised.’

A reasonable deduction from this very important concern is that there seems to be a link with the above issue, and that a reasonable conclusion to be drawn is that a significant number of practitioners whose communication or professional skills are in doubt are licensed to practice in the UK in the first place and belatedly ‘fished-out’ of the system only after their shortcomings have become obvious to others. This politically-fostered culture of ‘presumption of fitness’ is clearly not working.

Other areas of concern relate to systems being developed to handle increased general complaint processing in the GMC and revalidation of professional qualifications after a period in practice on the part of the registrant, both quite legitimate monitoring issues arguably.

However, in the interests of proportionality in the context of the GMC, it is fair to point out that under the heading of ‘Overall Assessment’ in the Report<sup>736</sup> the CHRE<sup>737</sup> make the point that “...the GMC has maintained and in many ways improved its levels of good performance across all of its regulatory functions this year.”

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<sup>734</sup> Written Ministerial Statement to the House of Commons of 26 March 2013 – referred to in the Health Select Committee (First Special Report) – (17 May 2013) – Government Response (Appendix 1) to the 2012 accountability hearing with the CQC (Seventh Report of Session 2012-13) – [www.publications.parliament.uk/pa/cm201314](http://www.publications.parliament.uk/pa/cm201314).

<sup>735</sup> Para. 11.24.

<sup>736</sup> Para. 11.3.

<sup>737</sup> Now renamed (and restructured as) the Professional Standards Authority from January 2013 pursuant to Section 222 of the Health and Social Care Act 2012 (2012, c.7).

## 9.5 A CQC 2015 inspection

Indicative of the new CQC inspection template and culture is a report from a Nuffield private hospital-registered general nurse that, on 9 March 2015, her matron and senior management instructed her to expect a CQC inspection at any time in the near future comprising possibly 10 to 13 inspectors. Inspector's powers are wide ranging and highly probative. The senior management were unable to prepare as they had for previous visits when senior management would form a reception committee for the inspectors and conduct the walk-around of the hospital. The format has therefore completely changed in this instance.

## 9.6 Conclusions

The above case studies provide examples of the wide range of problems and challenges that are related to delivering elderly care. These are partly because of the increasing numbers of elderly within the care system and the need for their care to be delivered effectively. Adopting the principle of a patient focus is likely to require considerable effort and cross-disciplinary support amongst health care professionals.

Cavendish was an enlightening exercise into the world of practical every day elderly care delivery at NHS and other institutions, private care homes and people's homes. In this respect, it has identified the realities of care delivery with shortcomings such as non-integrated delivery, and driven policy change. Recent Government effort in the integrated care direction has been achieved by the further statutory change in Section 121 of the Care Act 2014,<sup>738</sup> establishing the Better Care Fund to drive that purpose forward, but the need for it is ever present.

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<sup>738</sup> (2014, c.23).

In practical terms for the year 2015-16 the available sum is £3.8 billion, available for local areas to access, as a pooled budget for health and social care services as a joint initiative between the Department of Health and the Department for Communities and Local Government.<sup>739</sup> This has the appearance of yet another ‘top-down’ Government decentralisation attempt which rarely seem to work, but the actual implementation model identified by the National Audit Office would put a single financial fund into multiple local implementation mode as a ‘bottom-up’ expenditure reform. A greater chance of success is therefore likely, and the Manchester’ pilot’ just announced furthers this delivery template.

The latter latest ‘pilot’ accepts that budgets for care which sit with local authorities, and budgets for medical treatment which sit with the clinical commissioning groups (CCG’s) should be merged for the forthcoming Manchester pilot where a single combined board would be in joint charge of a single fund. Dementia with the elderly and strains on the public purse and need to find economies have brought about innovative thinking, but the outcome remains to be seen.<sup>740</sup>

A more recent Kings Fund view on these continuing issues concludes that a fundamental shift is required in the case of the elderly towards care that is co-ordinated around the full range of an individual’s needs, rather than based around single diseases, and which truly prioritises prevention and support for maintaining

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<sup>739</sup> *Adult social care in England: an overview* – National Audit Office (13 March 2014) Report to Parliament by the Comptroller and Auditor General HC 1102 : Paragraph 2.24 – which notes that health and wellbeing boards approve local plans for spending Better Care Fund allocations.-

<sup>740</sup> *Decentralising health care* – (28 February 2015)- The Economist – reporting on an announcement by George Osborne, the Chancellor of the Exchequer, on 25 February 2015 to transfer control of the £6 billion of public money spent on health care in Greater Manchester to local hands as a pilot scheme.

one's independence. Achieving this will demand more integrated working to ensure that the right mix of services is in true co-ordinated delivery.<sup>741</sup>

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<sup>741</sup> *Making our health and care systems fit for an ageing population* – The Kings Fund (2014) – D.Oliver, C.Foot, R Humphries [www.kingsfund.org.uk](http://www.kingsfund.org.uk)



## CHAPTER 10: Conclusions

### 10.0 Introduction

Beveridge's universalism model, probably inspired by Bismarck's legacy in 1907, delivered a post-1948 result of great change.

The last 40 years since the Nursing Homes Act of 1975 have seen an acceleration in regulatory intensity usually reacting to events, and completely lacking the holistic approach urged in March 2013 by the House of Lords Select Committee as being "essential".

In reality lack of trust in people and systems has gained great influence over events, and the National Audit Office Report of March 2014 paints a disturbing auditors view of what we are facing in terms of its expert advice.

The Care Quality Commission is the latest version of government reactionary remedies, but incrementally it has progressed from its original mechanical civil servant designed template. With its enormous remit, recently increased by the Care Act 2014, it remains to be seen how the experts it now has to employ will be financed in terms of increasing regulatee/taxpayer funding.

In identifying CQC and Monitor's regulatory failings, Francis secured the CQC's temporary future, but his urging a statutory duty of 'candour' will meet patient confidentiality and indemnity insurer/lawyer cultural barriers, as did his "whistle-blowing" policy which in February 2015 he admitted had a shocking outcome.

Privately owned care homes clearly harbour the greatest potential and actual abuse of the vulnerable elderly, evidenced by the CQC authorising hidden cameras in its desperation to address that issue.

Overcoming serious cultural issues in achieving “joined-up” care delivery probably means continuation of the unsustainable drainage of taxpayers funds, as does the uncontrollable negligence litigation situation. Probably a Welsh-type commissioner can aid the process.

Also, a dedicated regulator for elderly care seems likely to emerge perhaps.

The thesis has traced the development of elderly care from earliest times to contemporary arrangements in England. We have seen how elderly care concerns us all and this has been true from the earliest medieval times to the beginnings of statutory regulation and their eventual codification in the sixteenth century under the Hospitals for the Poor Act 1597.<sup>742</sup>

Since then, and throughout the intervening centuries, right up until contemporary times, the reform of social care and the care of the elderly has taken a pre-eminent importance in health care. Britain is remarkable because so much of elderly care is provided on a volunteer basis from within the close family, friends or relatives. It is also remarkable in the creation of the National Health Service after the Second World War included elderly care, and an increase in medicalization of care has raised expectations and created new possibilities for the professionalization of the provision of services for the elderly. Private care homes flourished and were often supported by local authority spending on behalf of the elderly.

Despite major achievements in setting up the NHS and providing various types of social and related care to the elderly, it is clear that the experience of many elderly people is not as it should be. There is heightened media and public concern, various authoritative reports and independent inquiries about abuse in care homes

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<sup>742</sup> (39 Eliz 1, c.5) – The whole Act remained in force until the whole Act was repealed by section 39(1) of, and Schedule 5 to, the Charities Act 1960 (8 & 9 Eliz 2, c.58) [www.legislation.gov.uk/ukpga/1960](http://www.legislation.gov.uk/ukpga/1960).

and cases of generally poor standards of elderly care underline the vulnerability of many elderly residents. This is a long way from the rather idealised view that elderly care comes from. Elderly care lies at the intersection of the relationship between Church and the State and the citizen based on religious, philosophical and cultural beliefs, and it concerns government, at both local and central levels. Increasingly it engages with the private sector.

Lawyers have traditionally looked at the elderly in terms of death, legacies and bereavement raising many legal issues including inheritance and estate planning, and care focused litigation. The Human Rights Act 1998 is also relevant.<sup>743</sup> Generally, with only a few exceptions, lawyers have not been interested in the legal regulation of elderly care and consequently there is a major gap in the literature on the legal aspects of elderly care.

Despite the growth in care homes and state provision for the elderly, it remains the case that elderly care needs are rising. The recent NAO report notes how the over 85s are rising faster than the population as a whole.<sup>744</sup> It is also at a time when local authority funding is being cut and is likely to fall. This is a trend since 2008/09 where local authorities are setting higher eligibility levels for elderly care long-term packages and cutting what is available. Nearly 85% of adults over 65 live in areas where only critical needs are being provided. This is an increasing trend leaving family and friends to provide a large proportion of elderly care with voluntary unpaid carers taking up the responsibility.

The aims and objectives of the thesis, unaddressed elsewhere by academic study, are to understand elderly care regulation as a case study of systemic

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<sup>743</sup> (1998, c.42) – Particularly in relation to its twice extended statutory remit to private care home and other private delivery.

<sup>744</sup> NAO, *Adult Social Care in England: Overview* HC 1102 Session 2013-14 ( 13<sup>th</sup> March 2014).

regulatory failures in elderly care. The main research question is how elderly care is regulated and delivered in the light of acknowledged failings, as detailed in the Francis Report and recent reforms introduced to improve the work of the Care Quality Commission in the context that care delivery is focused on the patient's experience and is of high quality.

The thesis excludes estate planning and the costs/pensions available to care for the elderly. The latter is a specialist subject in its own right with technical rules on pensions, social security and related issues that are impossible to address in a single thesis. This is also an important area that also needs some attention in terms of future research dedicated to those aspects of the subject.

Lately, accompanying continuing cultural change by each generation, the chronically ill have become part of a general debate about end of life provision, and assisted dying has become a central issue in debates on the right of an elderly person to determine the end of their life.<sup>745</sup> This is also an area of research that needs separate consideration and specialist research involving legal and moral issues that underpin much of the debate conducted in the forum of parliamentary and public discussion.

Events and developments are being continuously addressed in a sequence of events displaying the trappings of permanence, but the often politically driven response to developments which are hard to anticipate and difficult to analyse in a fast changing care environment is a substantial feature of the enormous challenge with which we are engaged. This process just at the regulatory tool level, including tougher CQC inspections and whistle-blowing, clearly demonstrate that legal rules

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<sup>745</sup> Which right Bentham's utilitarianism embraced. Note also that Sir Ian Kennedy (who was to become Chair of CQC's predecessor, HCC) in his 2001 Bristol Infirmary Report recognised that regulation of care delivery's multiple components needed a holistic approach to address what he called the "totality....of procedures and systems"

are only one aspect of complex elderly care delivery issues, and often a far cry from the practical outcome realities.

#### 10.1 Elderly Care in the 19<sup>th</sup> century to the Beveridge Report

The first three chapters trace the main historical developments of elderly care in Britain. The thesis begins with an historical focus that traces the delivery of elderly care as part of the development of the National Health Service and traces the development of the regulation of elderly care. In contemporary times, there is a noticeable shift from family-delivered elderly care to a hybrid/contractual delivery structure involving the state, private care companies and also a plethora of medical and care professionals. This shift can be deceptive as the bulk of elderly care is provided by volunteer arrangements within and around families.

Despite the growing interest and involvement in elderly care by experts, many families and friends provide on a voluntary basis a large amount of care for their elderly friends or relatives. This is often overlooked in the general discussion. The entry of many professionals and companies into the elderly care market is typical of the public/private relationship common to much of the health care delivery in the modern health service. It is also due to the provision of modern medical techniques that may extend the life of patients in circumstances that were impossible even a decade ago.

In Chapters 1 and 2, we have seen how the beginnings of elderly care are clear from earliest history. In Chapter 1, it becomes clear that the piecemeal engagement with the spectrum of elderly care issues so far generated by interested academics, has not fully addressed the legal regulation of elderly care. In the evolutionary process Prosser has well identified that legitimacy of regulation and the public's perception of the operation of trust and effectiveness, and that the

complexities of care delivery regulation, well beyond the economic regulatory one, may hold lessons for other types of regulatory oversight.

We have seen how elderly care has developed since earliest times. The intermix of elderly care with health care was largely due to limited life expectancy and care being a family responsibility operating within the family unit. This has largely broken down as the ageing population has been increasing and accompanying changes in family relationships with an increasing large female workforce,<sup>746</sup> but conversely the need for these females to engage more in paid work and less in voluntary care activities.

In Chapter 2, we traced the historical basis for long term elderly care. This was considered in the context of understanding the main contemporary issues that surround elderly care in the transition from medieval care systems to poor law workhouse structures. The culture of care and caring is in evidence from the way care was delivered as part of a moral social responsibility on the part of relatives and family members of the elderly, or the church or charitable organisations.

Also clear is that the last two or three decades have been engulfed by the litigation culture which is not only seriously draining financial resources in both the NHS and the private sector but has promoted a culture of secrecy within organisations fearing potential litigation. It is difficult to see how the new statutory duty of candour,<sup>747</sup> advocated by Francis, will noticeably impact on such a deeply embedded professional behaviour pattern historically supported by indemnity insurers.

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<sup>746</sup> As evidenced by the Nursing and Midwifery Council statistics – [www.nmc.org.uk/statistics](http://www.nmc.org.uk/statistics) and the Cavendish Review- *ibid*.

<sup>747</sup> Care Act 2014 (2014, c.23) – Section 81.

Another quite different but related serious issue, is the continuing lack of a proper advocacy ‘voice’ for elderly people that is equivalent to children to, in effect, counteract that secrecy. The effect that such a statutory ‘voice’ for the elderly could have on driving both culture change and transparency could be remarkable and dramatic, instead of the present reliance on a few charities and voluntary organisations for those purposes.

The apparent success of the role of the Older People’s Commissioner for Wales since emplaced by specific Welsh Assembly health and social powers delegated from Westminster in 2006,<sup>748</sup> together with that official’s joined-up healthcare delivery statutory intervention and extensive liaison focus, could be a pointer for England.<sup>749</sup> The Welsh role has been praised by independent charities such as Age UK Wales.<sup>750</sup>

There are discernible links between medieval and Victorian elderly care that have continued right up to contemporary times. Modern values around the family and friendships have been ‘informed’ by historic ones. This is again often overlooked in a secular world today. Religious and moral thinking and influences from different perspectives on the value of human dignity and its protection that come from deeply held personal beliefs may be forgotten. So it was that some of the leading figures of the day, including Bentham,<sup>751</sup> Gladstone<sup>752</sup> and Lloyd-George<sup>753</sup> helped shape their moral approach to the vulnerable in society including the elderly.

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<sup>748</sup> By the Commissioner for Older People (Wales) Act 2006 (2006, c.30).

<sup>749</sup> Reported in detail in *Driving Change for Older People: Impact and Reach Report 2013-14*- Older People’s Commissioner for Wales – [www.olderpeoplewales.com](http://www.olderpeoplewales.com)

<sup>750</sup> [www.ageuk.org.uk/walescommissioner](http://www.ageuk.org.uk/walescommissioner).

<sup>751</sup> *The Collected Works of Jeremy Bentham* – edited by Michael Quinn (Oxford: Clarendon Press – 2010).

<sup>752</sup> Roy Jenkins – *Gladstone: a biography* (London: Macmillan – 1995).

<sup>753</sup> Roy Hattersley – *David Lloyd-George* (Hachette Digital – 2010).

As Michael Hill has pointed out,<sup>754</sup> family care is very much the norm in most cases of elderly care and is not to be overlooked. It provides one to one care delivery for elderly members or relatives. It is comparable across the country, remaining a major component of elderly care today and this is premised on a supportive community and family ties working in an effective way.

Historically state support of families in their carrying out of support of their elderly 'burden' has been shown to the more effective policies of policy makers.

Other family arrangements are important. One means of keeping home for elderly relatives are life tenancy arrangements (formal legal ones, or even informal ones between different generations of an individual family). There is an increasingly large number of frail elderly people with less social and family support. The most vulnerable are the poor. Simultaneously, the historical use of voluntary organisations has given way to, but still co-exists with, branded and commercially-costed care delivery services, some of which delivery systems are already in crisis.

Hand in hand with social change, there has been a transition from relatively untrained care delivery in medieval pre-Reformation times up until a post-Reformation embryonic hospital structure came into place following the 1597 Act,<sup>755</sup> to the need for training being realised in the progress of the Crimea War,<sup>756</sup> when a public outcry revolving around Florence Nightingale (1820 – 1910)<sup>757</sup> intervening in nursing care in that War. That developed an incentive for professionalisation of such care including the medical profession itself.<sup>758</sup>

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<sup>754</sup> *Social Policy in the Modern World* – Michael Hill (Blackwell Publishing – 2006) - Chapter 12 'Ageing Societies'.

<sup>755</sup> *Ibid.*

<sup>756</sup> October 1852 – February 1856 – [www.bbc.co.uk/history/british/victorians/crimea](http://www.bbc.co.uk/history/british/victorians/crimea).

<sup>757</sup> [www.bbc.co.uk/history/historic\\_figures/nightingale](http://www.bbc.co.uk/history/historic_figures/nightingale).

<sup>758</sup> Medical Act 1858 – (1858 c.90) – but in the case of the medical profession the regulatory process began at least as early as the reign of Henry VIII with the Physicians and Surgeons Act 1511 – (3 Hen.8, c.11), but



In parallel with these developments, is the Industrial Revolution and the enormous urbanisation of industry, and relocation of people. New towns and cities accompanied enormous social changes over these decades with huge demands for public welfare such as the sanitation improvement. Elderly care did not attract much specific attention. The state legislated in a backdrop capacity to provide support when private sector charities could not cope.

In terms of the modern care delivery structures, which Chapters 2 and 3 demonstrate to have emerged from the historic ones, legislative development from elderly care appears to fit within the overall Beveridge model of delivery, to some degree. The complexities of elderly care which are due to the ageing population need to be addressed.

## 10.2 Elderly Care and the National Health Service 1948 to the Community Care Act 1990

The 1946/1948 Beveridge-inspired National Health Service was underpinned by the need to deliver the required cultural and training progression across the nation. At the same time there remained a strong tradition of almsgiving and regular donations such as to the “elderly in need” remained in evidence. Its historical roots of charitable work supports charities such as Age UK today; and very visible are voluntary charitable organisations (with religious or private origin) such as Lady Katherine Leveson Homes,<sup>759</sup> Methodist Homes<sup>760</sup> and Cheshire Disability (formerly

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centuries of self regulation or light regulation have demonstrated in themselves need for more recent reform to heavier supervision as a result of it being a major contributor to abuse.

<sup>759</sup> [www.leveson.org.uk](http://www.leveson.org.uk) A purely sample body in the discussion

<sup>760</sup> [www.mha.org.uk](http://www.mha.org.uk)

Cheshire Homes)<sup>761</sup> which over time were granted charitable status to take advantage of generous tax breaks from successive governments. These provide a responsibility analysis of how care is given by them. Contemporary Britain is more interested in elderly care than perhaps any period in its past. One reason is that the post war “baby boomers” are reaching retirement age with higher life style expectation.<sup>762</sup>

Statutory milestones early in the 20<sup>th</sup> Century, in the wake of Liberal benevolence, consist of the creation of state pensions by 1908 and a system of national insurance by 1911 providing support financially for elderly people. A major landmark in care came in 1948 after the Second World War. The birth of the NHS in July 1948 created a nationwide system of health care delivery to all citizens, including the elderly, at the point of need. However in the first two decades of the NHS is evident a political policy vacuum in respect of the other needs of the elderly, who were perceived to be well provided for with their guaranteed state pensions.

The thesis addresses particular problems with NHS hospital delivery of care to the elderly, in terms of ‘bed-blocking’ issues, etc. The NHS treats elderly care merely as a ‘component’ of overall care delivery but does not provide long-term care directly outside NHS hospitals.<sup>763</sup>

The aftermath of the Second World War brought about the eventual achievement during the 1950s and 1960s of better living conditions, better food and better medical care. Longevity followed with a transition from persons in families expecting to look after one elderly relative perhaps, not living much beyond the age

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<sup>761</sup> [www.leonardcheshire.org](http://www.leonardcheshire.org)

<sup>762</sup> In parallel with doctors also seeking their own life style expectations, creating a tension with their availability for the elderly, and others.

<sup>763</sup> Sometimes ‘culturally’ unwelcome to NHS care deliverers.

of 65, to the growth of a significant part of the population, assisted by more sophisticated medicine which prolongs longevity in an increasing way.

The popular media makes frequent use of the word 'care' and the term is probably more in use now in our society than at any time in our history.<sup>764</sup> One of many perspectives for William Shakespeare was "...crabbed age and youth cannot live together: youth is full of pleasance, age is full of care."<sup>765</sup>

Contemporary effects have swept it up into new perspectives including a clearly defined commercial sense of goods and services that may be traded and bought. Care was thought of as temporary or limited when life expectancy was low. Long-term care has now become a key element of the future.

So far as the word 'care' itself is concerned, a dictionary definition with various etymological meanings, does not do justice to the variety of uses and the complexity of the subject,<sup>766</sup> and as such is unsatisfactory.<sup>767</sup> In most major countries since the 1990s care has been engaged in reform. The United Kingdom began this process under the 1990 National Health Service and Community Care Act 1990.<sup>768</sup>

In Chapter 5, increasing local authority engagement with its National Assistance Act 1948 care and accommodation provision functions takes place in an otherwise very centralised national government world, but as the decades progress

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<sup>764</sup> Authoritatively derived from the Old English 'caru' (the noun) and 'carian' (the verb) both of Germanic origin and whether used as a noun or a verb continue to depend on contextual matters for meaning. ([www.oxforddictionaries.com](http://www.oxforddictionaries.com)).

<sup>765</sup> *The Passionate Pilgrim*- at XII.

<sup>766</sup> [www.oed.com](http://www.oed.com).

<sup>767</sup> Even the related and connected concept of "well-being" required nine separate criteria in Section 1 (2) (a) to (i) of the Care Act 2014 (2014,c.23) to endeavour to embrace the intentions of the Law Commission in 2011 in relation to use of definitions.

<sup>768</sup> (1990, c.19).

the value of greater use of domiciliary and other care provision by councils becomes more apparent to central government.

Also in this chapter we saw that the National Health Service and Community Act 1990 opened the door to private sector expansion followed by the 1997 Labour Party Election Manifesto recognising that there was an elderly care and funding crisis so that it put in place its promised Royal Commission on Long Term Care of 1999.<sup>769</sup> The latter then became the subject of some progress and some political side-stepping, so that the model of permanent Commission envisaged by the Royal Commission did not get put into place to oversee rapidly changing elderly care delivery and connected issues.<sup>770</sup>

The Labour Government of 13 years were perhaps over-reliant on the Commission's finding that "for the UK there is no demographic time bomb as far as long term care is concerned and as a result of this the costs of care will be affordable."<sup>771</sup> As we have seen from evidence in Chapter 5, the local authority home sector is in rapid decay and vanishing into the private sector because of the financial crisis.

### 10.3 Regulating elderly care

Regulating elderly care has become more and more complex and this is related to issues about accountability, public perception and the aftermath of systemic regulatory failures.

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<sup>769</sup> 1990 c.19.

<sup>770</sup> Instead the Government's response to the 1999 Royal Commission was to enact the Care Standards Act 2000 (2000, c.14) putting in place the National Care Standards Commission (NCSC) as a modernised regulator with a remit across the care delivery sector, but its short-lived existence (1 April 2002 – 31 March 2004) was triggered by Government reaction to the 2001 Kennedy Report into the Bristol Royal Infirmary (18 July 2001 – Cm 5207).

<sup>771</sup> (Cm. 4192-1)-*ibid.*

Chapters 6 and 7 trace the setting up of the Care Quality Commission and Monitor, and the important findings of the Francis Report. The main findings of the Francis Report were that some parts of the NHS have a culture that was not conducive to providing good care for patients or a supportive working environment for staff. At the heart of the issues is the daily production of statistics coupled with some being tempted to manipulate them; perhaps an existing nationwide sub-culture now in place which is going to be rather difficult to eliminate.

The target setting culture of modern times and the need to achieve volumes in patient treatment and care are, coupled with the statistics manipulation problem, completely in tension with the need to provide the appropriate quality of healthcare delivery, as the Stafford Hospital Report has illustrated.

The regulatory failure represented by the Francis Report in this Chapter also highlights<sup>772</sup> the question of accountability and responsiveness to whistle blowers<sup>773</sup> and public concerns. Regulatory failures such as those highlighted by the Francis Report,<sup>774</sup> and also from some of the inspection reports undertaken by the Care Quality Commission (CQC). Very significantly however in his main 2013 Report Francis embraces the CQC as a model requiring improvement not abolition.

There is also the importance of the various Select Committee examinations. Responses include strengthening the use of inspections and further interim statutory change, and the Care Act 2014.<sup>775</sup>

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<sup>772</sup> Evidenced at Stafford Crown Court on 28 April 2014 when the NHS Trust was fined £200,000 in respect of one individual's death in April 2007 from health & safety breaches ([www.bbc.co.uk/news](http://www.bbc.co.uk/news)). (With only a 'handful' of rare exceptions in the form of professional bodies striking off a few individuals).

<sup>773</sup> The 'third' Francis report of February 2015 illustrated an unexpectedly large problem with NHS employees reporting mostly bad experiences from 'whistle-blowing' on colleagues currently resulting in career problems, bullying, etc., from most of 20,000 responses. Complex cultural issues and challenges thereby arising are addressed in suggested new guidelines from Francis- (11 February 2015) – [www.freedomtospeak.org.uk](http://www.freedomtospeak.org.uk).

<sup>774</sup> Francis Report Ibid.

<sup>775</sup> For example, Health and Social Care Act 2012 (2012, c.7).

The issues of who is accountable and who regulates are always present. Accountability is defined as responsibility for an obligation to act in a certain way. That leads to complexities such as internal and external accountability on the part of individuals and organisations, and appears to offer the view that the “blurring of lines” between Parliament, the executive, government, and the regulators may even suit some purposes in the “blame-shifting” game when a crisis arises.

Identifying this, Julia Black also identifies the quite useful contribution to accountability of the National Audit Office (NAO) in view of its expertise, but its role is often confined to being that of an “after the event” auditor and it is often unclear which government “master” it is serving. An illustration arises in the way in which general care and nursing home regulation<sup>776</sup> “merged” with the Department regulated NHS and private hospital system.<sup>777</sup>

The current Care Quality Commission (CQC) regulatory role owes its origins mostly to regulatory failure much earlier. The 2001 Report into children deaths at Bristol Royal Infirmary chaired by Sir Ian Kennedy,<sup>778</sup> a very significant driver of change, led to the setting up of the Healthcare Commission (as the CHAI). The foundation by the Health and Social Care Act 2008 of the CQC in 2009 to register and regulate by statutory oversight all NHS and private hospitals, public and private care homes, general practitioners and dentists and ambulance services was a major change in care oversight.

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<sup>776</sup> Noteworthy in this process being the Registered Homes Act 1984 (1984, c.23).

<sup>777</sup> Post-Millennium. Nevertheless with the medical staff and other professionals in those hospitals, and in the care and nursing homes, having, as they still do now, oversight and regulation by their respective professional regulators such as the General Medical Council (GMC).

<sup>778</sup> Kennedy, being driven by the enormous impetus of his Bristol inquiry, being appointed first Chair of this Commission. Not elderly care at all but a major catalyst for regulatory change, affecting elderly care.

Enhanced by the post-Francis Care Act 2014, the present CQC is a much more significant regulator than its 2008/2009 origins, with a remit to protect the elderly and vulnerable amongst other functions.

How should elderly care homes and care delivery systems interacting with them be appropriately and effectively regulated? Today's CQC,<sup>779</sup> a pivotal regulator is accountable by statute to Parliament but engaging and interacting with the wide public and private care delivery industry it registers and monitors with other regulators, the product of amalgamation, reform, re-organisation and further reform.<sup>780</sup>

The main role of the CQC is inspection of NHS hospitals and GP practices across the care delivery sector as well as its multiple functions mentioned, but its regulation and inspection of care homes is a key element of this.<sup>781</sup> The role of regulation is also a major part of the statutory duties allocated to the CQC under the Health Act 2009 that is linked also to the NHS Constitution, with a greater emphasis on rights and social solidarity.<sup>782</sup>

As Prosser and others have pointed out, this is part of a complex interweaving of regulation alongside other regulatory functions across the care

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<sup>779</sup> Even the Draft Care and Support Bill 2012 which in Paragraph 1 preferred to work around the definition of "well being" as an 'outcomes'- focussed statutory approach, per modern regulatory parlance.

<sup>780</sup> Not least Sections 88 to 91 of the Care Act 2014 which provides for a new unitary board structure as well as new duties elsewhere to give care homes star ratings once again= See Appendix 6.

<sup>781</sup> Denis Campbell, health correspondent, *The Guardian* 16 September 2014: Poor NHS care kills up to 10,000 people a year, CQC chief claims – "In a withering criticism of standards in the health service, David prior, the chair of the Care Quality commission, warns that "many patients receive poor care.""

<sup>782</sup> Effectively a "mission statement" in statutory format - Section 1 of the Health Act 2009 (2009, c.21) created the NHS constitution and Section 2 created the statutory duty of the CQC and others to have regard to that Constitution, the CQC itself having been created by the Health and Social Care Act 2008 (2008, c.14) to commencing operating as regulator on 1 April 2009.

Section 2 sets out in detail a persons rights as an NHS patient the first principle of the Constitution as " The NHS provides a comprehensive service, available to all irrespective of gender, race, disability, age, sexual orientation or belief. It has a duty to each and every individual that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population."

professional spectrum.<sup>783</sup> At the heart of the regulatory structures are proactive roles that may be exercised by the Secretary of State as statutory overseer, accountable to Parliament, of many aspects of public and private care delivery systems. With the CQC Prosser has been clear about the overriding need for legitimacy in its constitutional accountability role.

The CQC, an inspectorate, is largely an example of ad hoc developments. It is an amalgam of ill-sorted past regulatory bodies, possessing statutory independence of functions, but nevertheless it visibly is embracing the NHS Constitution and its human rights component to drive improvement standards upwards. Since its original crises, following its 2009 emergence, the CQC has thereby become 'empowered', using additional expertise and financial resources recently offered by government to that end, but time will tell as to whether the CQC has therefore risen to those standards itself.

Already noted the development of the CQC is the product of many forces at work, but the enormity of its remit across the whole care delivery sector dwarfs in many respects the elderly care section of its responsibility. Its predecessor, the Healthcare Commission, the statutory name of which was the Commission for Healthcare Audit and Inspection (CHAI) (April 2004 – March 2009),<sup>784</sup> was part of the then fast developing culture of audit and testing of care quality and standards setting. In part, this was a response to setting contractual and commercial standards required by the commercialisation of the service. The Chair of the Healthcare

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<sup>783</sup> Tony Prosser - *The Regulatory Enterprise – Government, Regulation and Legitimacy* (Oxford: Oxford University Press – 2010) – P.112.

<sup>784</sup> Created as a 'body corporate' by Section 41 of the Health and Social Care (Community Health and Standards) Act 2003 (2003, c.43) when it received the Royal Assent on 20 November 2003. The same Act provided for it to take over the role of the Commission for Health improvement (CHI) on 1 April 2004 and introduced the Foundation Trust Hospital and its regulator, Monitor.



Commission (CHAI) Sir Ian Kennedy (now chair of IPSA),<sup>785</sup> began work and, over time, the role of the regulator beyond economic regulation took shape, engaging Ian Kennedy's philosophy of separation of regulatory role from that of care delivery.<sup>786</sup> Kennedy inspired much of the subsequent reform.

In terms of legal regulation, Professor Tony Prosser's significant contribution to the overall debate, has identified several strands of regulation as follows: "...it is important to minimise administrative burdens in social as well as economic regulation; this will make the enterprise of regulation more effective. However...better regulation is...regulation that respects the underlying policy and principles of the enterprise of which it is a part. If one role for regulation is to protect rights, the test will not only be one of whether it does so at least possible cost but of how well it does so."<sup>787</sup>

The main research undertaken for the thesis takes account of developments up until and including autumn 2014, particularly the passing of the Care Act 2014 on 14 May 2014.<sup>788</sup> The thesis supports the following analysis and conclusions. Concerns about elderly care are unlikely to be diminished in contemporary Britain. They are set to dominate most of this century, as recent events show, with private care of the elderly in many instances falling below acceptable standards.<sup>789</sup>

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<sup>785</sup> The Independent Parliamentary Standards Authority since 2009, an academic lawyer of high renown, previously a Chair of the Public Inquiry into children's heart surgery fatalities at the Bristol Royal Infirmary – (1998-2001); which Inquiry itself was a catalyst for change against Department of Health 'self-regulation' of its management of the NHS hospital structure and self-regulation by the different health professionals bodies.

<sup>786</sup> A separation of roles now appearing to be called into question by government in other regulatory roles, such as railways.

<sup>787</sup> Tony Prosser (and others) – *The Regulatory State: Constitutional Implications* (Oxford: Oxford University Press - 2010) – *The distinctiveness of social regulation*.

<sup>788</sup> (2014, c.23)

<sup>789</sup> "Hillcroft Nursing Home, Lancaster, - care workers jailed for abusing elderly residents" – The Guardian (Peter Walker) (10 January 2014)- [www.theguardian.com/society](http://www.theguardian.com/society).

Julia Black has correctly identified the main elements of the need for regulatory accountability. These are that whilst bodies such as the NAO have been able to support the calling by Parliament of regulators to account with the NAO's technical expertise and recourses, their use together with, for example, Parliamentary select committees, nevertheless leave considerable gaps not least because of the way Parliamentary business and those select committees are organised and empowered. Accountability at local level which would have considerably contributed to local CQC oversight has regrettably had to be removed on financial grounds.

Regulation is a continued process of negotiation, compromise and challenge on both sides of the regulator/regulated relationship and it is often hard for outsiders to see that. The blurring of lines across the regulator/regulated relationship is to some extent undesirable and can render compliancy redundant.

The accountability discussion engaged in by Oliver Quick, however, seriously raises the profile of the litigation culture to the lack of effectiveness of the accountability system at present. Doctors, nurses and carers whose training and employment terms promote a culture of hiding any admissions of liability for any failings in care, and this culture will take many years to eradicate in the overall accountability spectrum. This is particularly clear from the large volume of ongoing and complex cultural issues in the NHS many of which were identified by the 'whistle-blowing' report of Sir Robert Francis of February 2015, where even the statutory protection to whistle-blowers, the Public Interest Disclosure Act 1998,<sup>790</sup> has not sufficiently emboldened many in past and current cases. The obstructions to

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<sup>790</sup> (1998, c.23)- Section 43B was inserted by this Act into the Employment Rights Act 1996 (1996, c.18) to extend 'protected disclosures' by employees and others to cover, for example, the involvement of a criminal offence, or failing to comply with a legal obligation, or an event whereby the health and safety of any individual was endangered directly or indirectly by the employer.

career progression, bullying and legal advice which entails avoiding court battles or employment tribunal proceedings are all too common;<sup>791</sup> suggesting that urgent Government action to activate Francis's complex guidance is needed.<sup>792</sup>

One can only speculate as to what extent this is currently mirrored in the private care home sector,<sup>793</sup> which technically is encompassed by the 1998 Act,<sup>794</sup> but is significantly harder to litigate against when faced with smaller private employer organisations rendering, for example, potential re-instatement in another part of the organisation practically impossible and without the NHS benefit of help towards a potential job elsewhere in the vast NHS.<sup>795</sup>

Therefore it appears that the whistleblowing 'regulatory tool' of accountability is at best delivering some positive outcomes for elderly care delivery somewhere, but at worst is a dysfunctional mechanism for improving care delivery for overlapping, but slightly differing, reasons in the NHS and the private care home sector.

In terms of regulatory oversight, structures engaged with elderly care delivery do not possess the interlocking features they should have, and successive governments are unwilling participants in a huge 'experiment' of sorts seeking betterment, and for the last six years or so since the CQC came into being, endeavouring to move that body away from its not 'fit for purpose' earlier credentials.

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<sup>791</sup>(11 February 2015) *Ibid.* – [www.freedomtospeakup.org.uk](http://www.freedomtospeakup.org.uk).

<sup>792</sup> *NHS whistleblowing procedures in England* (23 February 2015) – House of Commons Library – Thomas Powell – Standard Note: SN06490- which mentions in this overlap between employment law and healthcare law that in Wales and Scotland employment law is not devolved by statute but health law is.

<sup>793</sup> In the light of Chapter 8's evidence that in 2013-14 English local authorities alone, said the Health and Social Care Information Centre, had investigated 35,810 allegations of care home elderly abuse- [www.theguardian.com/2014/oct/21/dilute-care-home-rules-law-abuse](http://www.theguardian.com/2014/oct/21/dilute-care-home-rules-law-abuse).

<sup>794</sup> Evidenced, for example, in the Employment Appeal Tribunal case in 2000 of *Care First Partnership Ltd v. Chubb and others* [2000] UKEAT 830\_00\_1207 where the appellant was the employer of 7 care assistants in a private care home for the elderly in Kent and the employees had reported a breach of health and safety legislation by the employer to the regulator and all alleged victimisation and constructive dismissal from their employment.

<sup>795</sup> Help recommended by Francis to be specifically encouraged by the Department of Health for NHS employees who are whistleblowers – House of Commons Library Note (23 February 2015) – *ibid*-Page 5.

However, we are engaged in very long term issues with no expectation of a model set of solutions.

The CQC debate can demonstrate precisely that comparative progressive incremental improvement, compared with earlier regulatory pre-Millennium regulatory systems has taken place. For the purposes of identifying what should be the 'care' component in that regulatory monitoring process, we have the absence of a holistic approach, which includes the Care Act 2014, but even that statute succeeds in identifying, for the first time, groups of elderly in need of care and does focus better on the individual seeking to make elderly care more effective.<sup>796</sup>

In conclusion, contemporary concerns about elderly care and ensuring that these are addressed correctly is a 'work in progress'. Specialist in nature and complex in operation may require a dedicated regulator or ombudsman expressly charged with determining the quality, effectiveness and cost efficiency of elderly care. The case is already compelling but the demographic changes that face an older community may make this option the least expensive and most affordable. Prevention is invariably better than trying to address serious problems once they have occurred.

Regulating elderly care is challenging. As evidenced in this thesis, accountability is key to our understanding of how elderly care systems might be improved and strengthened. At the local level between doctor, nurse/carer and elderly person this might happen as a result of the proposed 'duty of candour.'<sup>797</sup> But there is also the development of new systems, expertise and templates at the regulators own level and resourcing at the Department of Health and Parliamentary

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<sup>796</sup> For example, prescribed by Section 1(2), by using nine criteria to define "well-being", but expressly in a non-inclusive way.

<sup>797</sup> Section 81 of the Care Act 2014-*ibid*.

level with the “gaps” identified by Julia Black being eradicated, in which overall system the unfortunate withdrawal of Healthwatch in connection with its role for interacting for a committee locally for CQC is also unfortunate on financial grounds when the coalition government came into power. The displacing of bodies like Healthwatch will prove to be an ill thought-out reform, in her view, as it weakens regulatory accountability to citizens.

It is also a matter of incremental steps. At first, there was relatively little regulation. Then gradually in line with many public and private services with an economic import, regulation has become essential.

There is also the major shift in the last three decades which sees a transition from person-centred care delivery to demand led commercial care delivery by primarily the private sector, and that has presented ongoing challenges as to how private care homes are regulated and how service delivery is overseen. Kennedy’s influence on the oversight of that process has been very significant.

Apart from the obvious growth mentioned above, are slightly less obvious industries which have grown themselves, one example being the SAGA group.<sup>798</sup> This one example of an enormous growth industry which has emerged in recent decades is surely a matter some optimism for the eventual outcome from this in terms of the less financially dependent (on the state), pension restructured, future elderly person.<sup>799</sup>

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<sup>798</sup> On its website [www.saga.co.uk](http://www.saga.co.uk) – “Saga is a British company focussed on serving the needs of those aged 50 and over. It has 2.7 million customers. Saga Holidays provides package holidays and tours across the globe. Saga Insurance provides a wide range of insurance products (motor, home, travel, caravan, commercial van, pet, private medical, life insurance, motor-home). Saga Personal Finance provides savings accounts, credit cards, travel money, financial advice, equity release, share dealing, annuities, life assurance, and long term care funding advice.”

<sup>799</sup> However, in statutory terms, the Care Act 2014, progressively being implemented by ministerial parliamentary statutory instruments/regulations, has endeavoured to rebalance the focus from the institutional provision back to the person centred focus.

#### 10.4 Elderly Care Accountability, Human Rights

Chapter 8 traces the various medical and social care challenges facing the elderly today. Chapter 8 also considers the role of the courts including human rights cases, the progressive development of rights under the Human Rights Act 1998, and provisions of the Care Act 2014 such as those that extends rights to carer's.

Chapter 8 also shows the many and varied methods of accountability. This includes Parliamentary select committees but also the work of the National Audit Office has been highlighted. On 13<sup>th</sup> March 2014 an innovative overview of systemic and other care delivery issues was published by the National Audit Office.<sup>800</sup> "The NAO report concludes that "rising needs, reducing local authority spending, and reductions in benefits may be putting unsustainable pressure on informal carers and acute health services." Further, it comments that "National and local government do not know whether the care and health systems can continue to absorb these cumulative pressures, and how long they can carry on doing so."<sup>801</sup>

As Black also notes, the principal means the government has to control regulators and hold them to account through their budgets; for the majority...are at least part-funded by the state. Continuously Parliamentary select committee reports have criticized the government for obscuring the boundaries between its roles and responsibilities and those of the different regulators. Thus, much departmental blame has gone unnoticed, with implications primarily for ministerial responsibility for the Secretary of State for Health at the time, and to a lesser degree the Permanent Secretary of the Department at the time.

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<sup>800</sup> Adult Social Care in England: Overview, A Report by the Comptroller and Auditor General, Department of Health, Department for Communities and Local Government, session 2013-2014, 13 March 2014.

<sup>801</sup><http://www.pennington9ns.co.uk/news-publications/latest-news/national-audit-office%E>

Hence the NAO's limitations as a statutory body with reporting only functions and 'after the event', that is 'after the horse has bolted', come into focus.

#### 10.5 Case studies of elderly care: lessons being learnt

We have seen in Chapter 9, devoted to some case studies of examples of elderly care how complex and disconnected and varied elderly care delivery really has become today. The fragmentation of healthcare delivery issues raised also in this Chapter represent an ongoing structural defect in the care delivery system, costing billions of pounds when the State sorely needs to save and redirect such finance. In this latter respect there must be some cause for hope in the forthcoming Greater Manchester pilot model discussed, particularly as it is not another 'top-down' Government initiative purely demonstrating political goodwill but a 'bottom-up' model implemented entirely locally.<sup>802</sup>

The significance of private sector commercial providers in the delivery of care for the elderly has had far-reaching consequences for the role of local government and elderly care patients. The demographically created and driven hugely enlarged private sector care provision and its associated need to make profits almost ahead of worrying too much about the standard of care (except for regulatory pressures) has completely changed the landscape in care delivery.<sup>803</sup>

Evidence given in this thesis of the tension between the need to make profit and maximise profit and, therefore, the inclination to operate a minimum expenditure compliance with regulatory requirements model is very much in place and it is

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<sup>802</sup> *Decentralising health care*- (28 February 2015)- The Economist reporting on a new initiative announced by the Chancellor of the Exchequer on 25 February 2015.

<sup>803</sup> The Southern Cross crisis Ibid. is an example of a failed model of business care delivery, although in that particular case the business model itself was flawed or shown to be flawed.

difficult to see how this unsatisfactory situation is ever going to be eliminated unless there is a radical regulatory change.

The example of Southern Cross PLC that went into bankruptcy is a cautionary tale of economic vulnerability in the private care market, discussed below. Another example in Chapter 9, is the accident and emergency case study providing a “window” into the hospital system as a whole in general, and for elderly care in particular, and exposes cultural issues and medical staff retention issues of a serious nature, not least the bed blocking, particularly by the elderly with dementia. Interacting with these issues is the fact that there are now 61 approved medical specialties working in the NHS system needing to be interlinked with the multiple health issues presenting by many elderly persons going into hospital.

It is clear that importing caring values into modern society has met with mixed results but not least in today’s culture are those care workers on the minimum wage per hour. Contributing extensively to this sector of the debate was the Cavendish Review of July 2013,<sup>804</sup> which identified a number of cultural and other issues relating to this very large part of the elderly healthcare delivery workforce, part of which found lacking the quality of ‘feeling wanted.’<sup>805</sup> Cavendish nevertheless appears to have encountered in her research and interviews the practical heart of true care delivery, and the real meaning of ‘care’ as well as the cost of not having ‘joined-up’ elderly care delivery.

In regulatory terms, the Government has in effect adopted a “middle course” whereby it has identified certain central features of the Cavendish Review<sup>806</sup> which relate to basic essential standards being adopted between the most basic healthcare

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<sup>804</sup> [www.gov.uk/.../review-of-healthcare-assistance-and-support-workers](http://www.gov.uk/.../review-of-healthcare-assistance-and-support-workers).

<sup>805</sup> The Cavendish Review Ibid. – Paragraph 10 Overall Conclusions – 10.1.

<sup>806</sup> The Cavendish Review Ibid.



worker and those that wish to move into formal nursing training and essentially, therefore, finding a way of ‘filling the gap.’<sup>807</sup> Inherent in these debates and findings is the clear presence of the need to rediscover, in certain public and private care delivery sectors, the medieval concept of ‘care’ in systems of modern care delivery and this is an important lesson from the thesis.<sup>808</sup> It is also consistent with Sir Ian Kennedy’s desire to place good care at the centre of the patient’s experience.

Relevant to this contribution to this part of the debate is the commitment by the Coalition Government not to, in principle, regulate all healthcare workers who are paid at or just above the ‘minimum wage’ as the same would, in the Government’s view, cause unnecessary financial pressures on people working in that part of the healthcare sector which the Government considered would not necessarily be constructive to overall healthcare delivery and its need to change its culture, not achievable by regulatory changes alone.<sup>809</sup>

In 2014,<sup>810</sup> the Law Commission put forward proposals for the restructuring of the nine bodies (and associated ones) involved in the professional care delivery regulatory sector who will<sup>811</sup> supervise or otherwise interact with those workers identified by the Cavendish Review and, therefore, the way in which the future health professional regulation is going to unfold. The complexities of levels of accountability by a large diversity of health professionals to individual elderly persons has driven the case for reform.

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<sup>807</sup> [www.gov.uk/government/news/new-proposals-to-ensure-care-and-compassion](http://www.gov.uk/government/news/new-proposals-to-ensure-care-and-compassion) - Department of Health (10 July 2013) – which among other things committed the Government to provide further responses to the Cavendish Review, some being addressed by Sections 95 to 98 of the Care Act 2014 – *ibid*- in terms of provisions of training for care workers.

<sup>808</sup> Yet as Chapter 4 identified, Methodist Homes with its delivery of elderly care according to Christian values for the past 70 years achieved a continuous high rating from the industry monitors, Laing & Buisson.

<sup>809</sup> Health Service Journal – 26 March 2013 – [www.hsj.co.uk/news](http://www.hsj.co.uk/news) which effectively rejects a recommendation to the contrary by the Francis Report *Ibid*. – Executive summary – para 1.194.

<sup>810</sup> [www.lawcommission.justice.gov.uk/projects](http://www.lawcommission.justice.gov.uk/projects).

<sup>811</sup> Including not least those regulated by the GMC and the NMC.

Consideration of the Care Act 2014 is included in the thesis in the wake of the Francis Report and CQC regulatory failure with the Mid Staffordshire NHS Foundation Trust Hospital represents some regulatory progression. The 2014 Act revisits issues relating to the dire need for systems of 'joined-up' care delivery. However, yet another, statutory duty in Section 3,<sup>812</sup> to promote the integration of care delivery attempts, but will not on its own address, radically changing entrenched 'ground level' cultural issues by NHS staff who won't talk to, or share data with, local authority social workers. New statutory duties will only deliver on the part of the professionals involved the appropriate 'payment of lip-service' to those disjointed sectors of care delivery.

The dire need to get 'joined-up' care delivery right leaves the Welsh Older People's Commissioner model up for investigation and study for its potential adaptation in England. Its striking difference is that it does not seek to bridge entrenched cultural differences amongst care delivery people working for different employers in the sector, but enables one official and her staff, armed with extensive legal intervention and liaison powers to drive co-ordination change. Indeed, given the CQC's improving and pivotal role which has identified the urgent need to drive care home improvement in particular, plus the likelihood of a specialised CQC for the elderly eventually, the apparent success of the Welsh Commissioner could perhaps all combine into an elderly person's future 'champion' with the minimum of legislative or structural change.

Departmental and individual evidence given to various Select Committee hearings indicated there was an acceptance of an undercurrent of restructuring fatigue in both the NHS itself as a structure and the CQC as its independent

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<sup>812</sup> The Section is headed "Promoting integration of care and support with health services, etc".

regulator, with successive governments getting involved in putting in place their own perceived need for change.

Healthcare delivery to the elderly is a most complex ongoing debate which is more challenging in many respects in terms of its change on a daily basis, even more so than other sophisticated regulatory regimes, such as the legal profession and the Health and Safety Executive and its regulatees. Consequently the need for continuing Government intervention is quite intense and very ‘confronting’ for all concerned in healthcare delivery.

Chapter 9 has analysed the large shift to the private sector with large numbers of care providers having the benefit of lack of transparency in terms of private limited companies having the status of “small companies” and, therefore, not being required to produce a profit and loss account if their turnover for a specific year does not exceed £6.5M.

The worrying lack of essential ‘shop-window’ information which already extends to limited liability partnerships is concerning, and there is no transparency for care users or potential users of elderly care services for private individuals and partnerships running care homes as well. That Chapter also looked at regulatory events leading to the formation of the Care Quality Commission (CQC) regulatory model with its continuity a flawed, but improving, template. In the wake of the Southern Cross failure discussed in Chapter 9 is also the evidence that across the UK in the Summer of 2013, almost a third of care homes run by smaller private companies were financially unstable, and we possess a regulatory system which simply will not be able to engage with that aspect.

Chapter 9 also looks at the home care delivery issues in particular revolving around the systemic separation in the system of experienced and trained

geriatricians<sup>813</sup> from the elderly persons who most need their skills. Also on the home care delivery front, the information gathered in their report by the Equality and Human Rights Commission<sup>814</sup> (EHRC) raises extremely worrying issues about various abuses, added to other care home abuse statistics already identified in the thesis.

With periodic changes in leadership, the CQC appeared to be purely functioning on a mechanical level with, historically, unsophisticated inspectors alongside a numerical shift of elderly care delivery into a huge private sector world with its multiple care delivery legal structures and the inability of the CQC to understand those structures<sup>815</sup>. The refocus and implementation post September 2014 into sophisticated inspections and more pre-inspection data analysis has certainly progressed the CQC regulatory template.

## 10.6 Conclusions

In the lifetime of many people born in the post-Second World War ‘baby-boom’ elderly care has transitioned from small beginnings to a rapidly expanding industry, on a truly ‘industrial’ scale, with which development in ‘leaps and bounds,’ government has endeavoured to periodically address, often functioning in a ‘fire-fighting’ role in both the private and the public sectors.

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<sup>813</sup> And even a ‘new breed’ of GP geriatricians (included in parts of the overall debate).

<sup>814</sup> Who themselves cannot correctly interpret judicial decisions, such as that of the Supreme Court in the McDONALD case (see Chapter 5 above).

<sup>815</sup> Admitted to be the case by David Behan (the CQC Chief Executive appointed in June 2012) in his evidence to the House of Commons Health Committee late in 2013 – per its official report (22 January 2014) – Sixth Report of Session 2013-14 HC 761.

As life expectancy is greater than in the past,<sup>816</sup> there is greater demand on pensions and on old age provision. At the same time, there is a higher incidence of dementia, Parkinson's disease and post-stroke rehabilitation recovery, with greater dependency on the state as families struggle to come to terms with the sharing of responsibilities and obligations between themselves, local government and the state.

The enormity of the growing chronic illness volumes of elderly alone is a great future resource challenge. Compounded with the growth of dementia and stretching the skills, or lack of them, on the part of the army of care deliverers, is a formidable forward vision. There is also a further aspect of elderly care today that has attracted legal interest. There is a widespread use of litigation that seeks compensation from the health service for mistakes and errors. This often compounds the problem of providing patients and their relatives with a degree of candour and also becoming a shield against better transparency. Medical professionals may fear litigation and become risk averse and suspicious of patients and relatives. Within this is the confidentiality of the doctor-patient relationship, not unlike the solicitor-client duty of care culture.<sup>817</sup>

This may unwittingly contribute to a culture that obscures transparency, and may enable doctors and nurses not to admit mistakes.<sup>818</sup> Allied to this trend is the

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<sup>816</sup> In the early 1530s average life expectancy was 38 years – [www.bbc.co.uk/history/british/tudors](http://www.bbc.co.uk/history/british/tudors).

"In 1901 life expectancy at birth was around 45 for men and 49 for women. By 1951 it had increased to 66 for men and 70 for women...By 2010 life expectancy at birth was 78 for men and 82 for women"- [www.parliament.uk/business/publications/research](http://www.parliament.uk/business/publications/research).

<sup>817</sup> Joan Loughrey, 'Accountability and the Regulation of the Large Law Firm, *The Modern Law Review* (2014) 77(5) 732-762. She discusses the apparent lower accountability of larger legal firms and the implementation in the last two years of a new regulatory structure for law firms pursuant to the Legal Services Act 2007, and the implementation by the Solicitors Regulators Authority (SRA) of internal senior management self-regulatory reporting structures as an innovation for the legal profession. This is a turn about from the views professed by Professor Ian Sutherland following the Bristol Royal Infirmary report 2001 – where he advocated the complete separation of regulator and regulatee in care regulation circumstances.

<sup>818</sup> Oliver Quick, 'Patient Safety and the Problem and Potential of Law, *Journal of Professional Negligence* (June 2012) -. Identifying the shortcoming of clinical negligence and other litigation against doctors and nurses and institutions the lack of a statutory 'duty of candour' is perhaps a serious fault. Section 81 of the Care Act 2014

countervailing tendency to inspect and spot check care home facilities. Now the complexities and failures of elderly care delivery have precipitated more complex monitoring templates and systems, and exposed the gaps. Hidden cameras used by patients and their families when they suspect some abuse is now actively encouraged by the regulator.<sup>819</sup>

Public institutions have come under heavy criticism and there are greater demands for accountability and responsibility. Public confidence and trust issues demand that the delivery systems for elderly care have their failings and shortcomings addressed, but Julia Black<sup>820</sup> for one demonstrates that present systems of accountability across the regulatory UK world are ‘too patchy.’

This is part of a wider analysis that shows that the credibility of once trusted institutions are open to question. Public concern and disquiet has come in the wake of allegations about general abuse from clergy, nuns and teachers as well as care assistants and professions. In the private care home sector, currently are enormous human rights and other abuse of the elderly issues, with the local authority abuse statistics alone showing that regulatory systems have hardly engaged yet with an enormous scandal.

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has just enacted a statutory ‘duty of candour’ but it is to be framed by ministerial regulation and therefore its exact structure and how that will work is at present unclear. He identifies that in the period between 1978 and 2006 the level of claims against the NHS increased dramatically by 1200 per cent in terms of clinical negligence and other claims in tort. *NHS Litigation Authority Reports and Accounts 2012-2013* – from 8654 claims of clinical negligence and 4346 non-clinical negligence from 2010-2011, this has risen by 10.8 per cent for the year 2012-2013. In terms of financial cost 86.3 million was paid in connection with clinical negligence alone 2010-2011.

<sup>819</sup> [www.cqc.org.uk/hidden-cameras](http://www.cqc.org.uk/hidden-cameras) (12 February 2015) – using hidden cameras to monitor care.

<sup>820</sup> Julia Black, ‘Calling Regulators to Account: Challenges, Capacities and Prospects’, in *Accountability in the Contemporary Constitution*, ed. Nicholas Bamforth and Peter Leyland, Oxford: Oxford University Press, 2013. She discusses the complexities arising from the UK, EU, and International treaties/agreements sources of law giving rise to regulatory systems in the UK fault lines arising from ‘blurring of boundaries’ between the different public bodies involved across the regulatory spectrum in connection with any specific regulatory remit in the UK.

Another discernible feature of the current system of elderly care delivery is the management of care. There are recognisable trends. The first is the use of accountancy techniques and systems of accounting and audit. Accountants can check figures after the event, but with elderly care delivery “care” engages much more complexity to regulate before during and after the event than financial services. There is a continuing lack of any “holistic regulation” across all parts of the system of delivery of elderly care, not least of which is some of the elderly being bullied by their own relatives and neglected (largely behind closed doors) by their own contracted carers. Absent has been any political consensus for long term holistic strategy.

Constant challenge and reform has attended the system, including in the wake of the financial crisis of 2008, the election of a Coalition government and the creation of new strategies for health service reform. As will be explained, successive governments have been faced with systemic public sector and individual private company failures requiring regulation of them to be re-addressed for the future.

It is noteworthy that societal expectations have also changed in terms of culture and also the raising of benchmarks generally<sup>821</sup>, and there are widening demands on the workforce in terms of personal social services. This has displayed growth in terms of employment opportunities and responsibilities, but the related need for more training, with its attendant additional cost, will provide continuity of challenge in its own right.

An additional set of problems arises for placing patient care at the centre of the NHS, is challenging because it is a fast changing area of regulation that constantly demands flexible responses as well as strong leadership.<sup>822</sup> Patient

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<sup>821</sup> Carrying obvious implications for greater training need and the growth of the cost of providing such.

<sup>822</sup> But at least the UK has a ‘flexible’ constitution in terms of the effects of individual statutes not requiring potential challenges in a constitutional court as in Germany and the USA: see Laws, L.J.’s judgement in the case

choice, human rights and social care sit uneasily with economic regulation. This has profound implications for the personnel, the type of regulation and the mode of delivery.<sup>823</sup> Reconciling economic and social forms of regulation are not going to be easy. Compromises in the past have led to vagueness and indecision. Not least is the challenge of cultural ‘marriage.’

Oversight of the regulatory systems is also essential especially in terms of overall parliamentary accountability through select committees of the House of Commons, having already identified from Julia Black and others that there are gaps in the accountability system.<sup>824</sup> The care crisis is linked to a regulatory crisis and this in an on-going and largely unresolved problem, but the regulatory structures ‘bolted together’ by government are still unsatisfactory.

The thesis has shown how the development of regulation through the Care Quality Commission (CQC) is a case study showing responses to regulatory failures. At the same time, NHS care of the elderly is undergoing a serious mid-life crisis in terms of the quality of care, the provision of adequate funding arrangements and the appropriate approaches to regulation.

The CQC itself, having had to have undergone significant change since its more modest origins, offers lessons for other regulatory bodies.

The recent Francis Report, with its more recent 2015 ‘whistle-blower’ sequel, is potentially an important new beginning for the NHS with significant implications for long term care and the elderly, but time will tell whether it was worth all the effort and

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of THOBURN v SUNDERLAND BOROUGH COUNCIL [2002] EWHC 195 for an exposition of our flexibility in this sense.

<sup>823</sup> One only has to look at the enormous range of personnel and their quite differing cultures (within nine different professional bodies including the General Medical Council) under the remit of the meta-regulator, the Professional Standards Authority, to see this.

<sup>824</sup> Julia Black, ‘Calling Regulators to Account: Challenges, Capacities and Prospects’, in *Accountability in the Contemporary Constitution*, ed. Nicholas Bamforth and Peter Leyland, Oxford: Oxford University Press, 2013.



expense. The Francis Public Enquiry itself necessarily had to address systemic and cultural issues first, whilst the Law Commission was independently looking at the regulation of the nine health professional bodies and their separate regulatory complexities as a separate exercise. The Government needs next to engage the Law Commission's recommendations for anticipated reform there.

Those further regulatory changes will amount to a much needed modernisation exercise to improve the functioning of those accountability systems. It is evident from previous chapters that the regulatory regime for elderly healthcare as a whole is functioning to a greater or lesser degree in terms of what might be identified as incremental success at certain levels. Merging (the smaller regulator) Monitor with the larger CQC,<sup>825</sup> proposed by Francis is worth considering.<sup>826</sup>

In the health care regulatory world it remains to be seen whether EU views and Directives on regulatory independence might emerge to distance the relationship of the CQC from the Department of Health as in the last decade with telecommunications regulation.<sup>827</sup>

Finally, may be offered the view that if the cultural, systemic and joined-up care delivery challenges are largely overcome, finance, or rather the diminishing availability of it, including the need to control in the above changes the spiralling cost of negligence litigation, represents an enormous challenge for generations to come. The severity of public funding cuts alone seem set to drive forward an upward pressure on family, friends and neighbours to help delay the process of care home use.

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<sup>825</sup> Francis Report Ibid. – Executive summary – para 1.146.

<sup>826</sup> As at least one Commons committee recognised in Chapter 4, the CQC needs no more mergers.

<sup>827</sup> Council Directive (EC) 2002/21 on a common regulatory framework for electronic communications networks and services [2002] OJ L108/33, Art. 3(2); Council Directive (EC) 2009/140 amending Council Directive (EC) 2002/21 [2009] OJ L337/37.

The permanence of the lack of any model set of solutions to these very long term issues seems guaranteed.

## APPENDICES

### APPENDIX 1

#### A1.1 Extracts - The Beveridge Report (November 1942)<sup>828</sup>

For the purposes of this study, from within the great detail of the 299 pages of the Report and its 23 recommended changes can be extracted the following relevant material:-

“CHANGE 5 – (page 48) – .....setting up of a comprehensive medical service for every citizen, covering all treatment and every form of disability under the supervision of the Health Departments.

CHANGE 7 – (page 53) - ....insurance for retirement pensions to all persons of working age, whether gainfully occupied or not.

CHANGE 9 – (page 54) – Assimilation of benefit and pension rates for unemployment, disability, and retirement.

CHANGE 14 – (page 59) – Making of pensions.....conditional on retirement from work and rising in value with each year...

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<sup>828</sup> *Social Insurance and Allied Services* – Report by Sir William Beveridge (November 1942 – Cmd.6404).

CHANGE 17 – (page 64) – Replacement of unconditional inadequate widows pensions.....

RETIRED PERSONS (page 87) – (an analysis of food and clothing needs)

THE PROBLEM OF AGE (page 90) – (an analysis of poverty and other issues with demographic projections each decade until the year 1971)

THE SOCIAL SECURITY BUDGET – (an analysis supported by Appendix 'A' to the Report consisting of a memorandum from the Government Actuary)

ADMINISTRATION (page 145) - .....undertaken by a Ministry of Social Security under a Cabinet Minister.....with a Statistics and Intelligence division (page 148, paragraph 398)

COMPREHENSIVE HEALTH AND REHABILITATION SERVICES (page 158, para 426) - ....a national health service for prevention and for cure of disease and disability by medical treatment.

Most of the problems of organisation of such a service fall outside the scope of the Report.

ABOLITION OF WANT AS A PRACTICABLE POST-WAR AIM (page 165, para 444).<sup>829</sup>

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<sup>829</sup> (Cmd.6404)-*ibid.*

## APPENDIX 2

### A2.1 PART ONE

#### EXTRACTS – ROYAL COMMISSION – WITH RESPECT TO OLD AGE:

LONG TERM CARE – RIGHTS AND RESPONSIBILITIES – (MARCH 1999 – Cm 4192-I) :

“We, the undersigned Commissioners, having been appointed by Royal Warrant on 17 December 1997 to examine the short- and long-term options for a sustainable system of funding of long-term care for elderly people, both in their own homes and in other settings, and, within 12 months, to recommend how, and in what circumstances, the cost of such care should be apportioned between public funds and individuals, having regard to:

- the number of people likely to require various kinds of long-term care both in the present and through the first half of the next century, and their likely income and capita over their life-time;
- the expectations of elderly people for dignity and security in the way in which their long-term care needs are met, taking account of the need for this to be secured in the most cost-effective manner;
- the strengths and weaknesses of the current arrangements;

- fair and efficient ways for individuals to make any contribution required of them;
- constraints on public funds; and
- earlier work done by various bodies on this issue.

The Commission should also have regard to:

- the deliberations of the Government's comprehensive spending review, including the review of pensions;
- the implications of its recommendations for younger people who by reason of illness or disability have long-term care needs;
- the cost of its recommendations; and
- the views of all interests likely to be affected by its recommendations, in particular to users and carers.

## A2.2 Executive Summary and Summary of Recommendations

The Commission have begun from the point of view that old age should not be seen as a problem, but a time of life with fulfilments of its own. To provide security in old age and proper care for those that need it our main recommendations are that:

- The costs of long-term care should be split between living costs, housing costs and personal care. Personal care should be available after assessment, according to need and paid for from general taxation: the rest should be subject to a co-payment according to means.
- The Government should establish a National Care Commission to monitor trends, including demography and spending, ensure transparency and accountability in the system, represent the interests of consumers, and set national benchmarks, now and in the future.

### A2.3 The Commission's Overall Conclusions

The broad outline of the Commission's conclusions is as follows:-

- For the UK there is no "demographic time-bomb" as far as long-term care is concerned and as a result of this, the costs of care will be affordable;
- Long-term care is a risk that is best covered by some kind of risk pooling – to rely on income or savings, as most people effectively have to do now, is not efficient or fair due to the nature of the risk and the size of the sums required;
- Private insurance will not deliver what is required at an acceptable cost, nor does the industry want to provide that degree of coverage;



- The most efficient way of pooling risk, giving the best value to the nation as a whole, across all generations, is through services underwritten by general taxation, based on need rather than wealth. This will ensure that the care needs of those who, for example, suffer from Alzheimer's disease – which might be therapeutic or personal care – are recognised and met just as much as of those who suffer from cancer.
- A hypothecated *unfunded* social insurance fund would not be appropriate for the UK system; A *prefunded* scheme would constitute a significant lifetime burden for young people and could create an uncertain and inappropriate call on future consumption;
- The answer lies in improvement of state provision, but the state cannot meet all the costs of “long-term care” in the broad sense. The elements of care which relate to living costs and housing should be met from people's income and savings, subject to means testing, as now, while the special costs of what we call “personal care” should be met by the state. This would cost between £800 million and £1.2 billion a year (at 1995 prices);
- Currently an estimated 2.2% of taxes from earnings, pensions and investments is spent on long-term care in residential settings and in people's homes. Improving entitlements in the way we propose will add 0.3% to this bill, rising to 0.4% in the middle of the next century;

- Although people will still need to meet their living and housing costs should they need care, it will be clear what they will need to make provision for – and such provision will be affordable by more people;
- Other options are available at a lesser cost to make specific improvements to the current system. They include disregarding the value of the house in the means test for 3 months, changing the limits of the means test, and making nursing care wherever it is provided free. Each option would involve increases to current spending each year of between £90 million and £220 million;
- Because of the uncertainty of the data, the lack of trust in the present system among older people, and the cynicism as to Governments' future intentions which exists amongst younger people, a new body, the *National Care Commission*, should be established. Its task would be to look at trends, monitor spending, ensure standards, and visibly represent the voice of the silent majority of consumers now and in the future;
- The system needs more effective pooling of budgets, including bringing the budgets for housing aids and adaptations into a single pot;
- The Commission recommended that more care is given to people in their own homes. Therefore the role of housing will be increasingly important in the provision of long-term care;

- More services should be offered to people who have an informal carer;

The Commission's recommendations represent a unique opportunity for a new contract between Government and people and between all generations of society.

#### A2.4 Summary of Recommendations

Our main recommendations:

- *The costs of care for those individuals who need it should be split between living costs and personal care. Personal care should be available after an assessment, according to need and paid for from general taxation: the rest should be subjected to a co-payment according to means.*
- *The Government should establish a National Care Commission which will monitor longitudinal trends, including demography and spending, ensure transparency and accountability in the system, represent the interests of consumers, encourage innovation, keep under review the market for residential care, nursing care, and set national benchmarks, now and in the future.*

On funding we recommend:

- *The Government should ascertain precisely how much money, whether from NHS, Local Authority Social Services and Housing budgets, or from Social Security budgets, goes to supporting older people in residential settings and in people's homes.*
- *The value of the home should be disregarded for up to three months after admission to care in a residential setting (with appropriate safeguards to prevent abuse) and the opportunity for rehabilitation should be included as an integral and initial part of any care assessment before any irreversible decisions on long-term care are taken.*
- *Measures should be taken to bring about increased efficiency and improved quality in the system, including a more client centred approach, a single point of contact for the client with devolved budgeting, budgets shared between health, social services and other statutory bodies and greater integration of budgets for aids and adaptations.*
- *The Commission set out a number of other changes to current system, such as changing the limits of the means-test, or making nursing care free, which would be of value in themselves, but which would be subsumed by our main recommendation.*
- *The resources which underpin the Residential Allowance in Income Support should be transferred to local authorities.*

- *Budgets for aids and adaptations should be included in and accessible from a single budget pool and a scheme should be developed which would enable Local Authorities to make loans for aids and adaptations for individuals with housing assets.*

On the provision of services we recommend:

- *The role of the advocacy should be developed locally, with backing from central Government.*

On help for carers we recommend:

- *The Government should consider a national carer support package.*

On information and projections we recommend:

- *The National Care Commission should be made responsible for making and publishing projections about the overall cost of long-term care at least every five years.*

A2.5 Implementing the Commission's recommendations:

- Many of our recommendations can be implemented without the need for primary legislation. Examples include the disregard of housing assets for the

first three months, changing the means-test limits, or extending the provisions of free nursing care. The National Care Commission could be established as a shadow body within Government. We would urge the Government to implement our proposals as soon as possible. The need for change is pressing.”

## A2.6 PART TWO

### A2.6.1 STATEMENT BY THE ROYAL COMMISSIONERS – SEPTEMBER 2003

SIGNATORIES – LORD SUTHERLAND OF HOUNDWOOD, DAME JUNE CLARK, SIR NICHOLAS GOODISON, DR IONA HEATH, PROFESSOR MARY MARSHALL, CLAIRE RAYNER, PAULA RIDLEY, PROFESSOR ROBERT STOUT, ROBIN WENDT

#### “The Statement’s Purpose

1. Nearly five years on from publication of the Royal Commission’s Report in March 1999, there is still a live debate about long-term care of older people and its funding. Little has been resolved. Governments in most of the United Kingdom still decline to act. There is widespread concern. This is an important issue not just for older people and their families, but also for the wide public.
2. So it is right and in the public interest that Commissioners should re-visit their Report in the light of developments since it was published. This Statement represents the considered and collective views of nine Royal Commissioners who were full signatories to the Report and who have continued to meet together since March 1999.

3. In this Statement the Royal Commissioners review the extent to which the long-standing problems with long-term care and its funding, which prompted the establishment of the Royal Commission, have been resolved since it reported.
4. We are indebted to the many organisations and individuals who, having informed the Royal Commission's original recommendations, have continued to make representations on long-term care. They have helped to ensure the continuation of an informed public debate which is an important context for this Statement.

#### A2.7 Proposed National Care Commission

7. The Royal Commission unanimously supported the establishment of a National Care Commission. Our work convinced us that long-term care is an issue with so many inter-related facets – social, economic, financial and others – that a permanent, powerful body is needed to ensure that they are all kept under proper review. This would also rule out any call for a further Royal Commission in say twenty-five years' time.

#### A2.8 The Current Position

##### A2.8.1 General



14. With the exception of England, the Royal Commission's approach to care funding has clearly had at least some impact on Governments. As yet, however, this has been translated into equally clear action only in Scotland. More than four years on, there has been no reasoned rebuttal of the Commission's care funding proposal on policy grounds.
15. If Governments had accepted the Commission's proposal in principle, but declined to fund it for expenditure reasons, that would have been at least an unambiguous response. As things stand, there is a policy vacuum in this area.
20. The distinction between nursing and personal care is not simply artificial nor publicly understood. In an age of consumer choice it is essentially a producer-driven approach. The needs of patients should always come first. The current funding regime, by linking entitlement to care given by nurses, puts providers before patients. Nurses are in effect the gatekeepers to free as opposed to means-tested care. There is more than a hint that government has decided how much money should be spent on care funding and has devised a pragmatic way of spending it without regard to patients' needs. This is the opposite of how older people should be looked after.
23. On residential care generally, the pressures in the care system towards institutionalisation are still strong, despite the Royal Commission's design of a funding regime designed to minimise them.

24. Older people are still not being discharged from hospital when they should be. Free nursing care by itself has patently failed to address this. Most so-called 'bed-blockers' are people with dementia who generally do not get nursing care outside hospital. Their numbers are reliably predicted to increase. Six years on from the appointment of the Royal Commission delayed discharge gets no better.

#### A2.8.2 Institute for Public Policy Research

29. In 2002 the Institute for Public Policy Research analysed progress in both pensions and long-term care, set against the Government's objective of eliminating pensioner poverty.<sup>830</sup> Like the Royal Commission the IPPR approached the issue of care funding from first principles. It came to exactly the same conclusion as the Royal Commission, that both nursing and personal care should in principle be free; and for much the same reasons. Coming from this respected and independent source, the IPPR Report is a powerful endorsement of the Royal Commission's own conclusions.

#### A2.8.3 Research

31. The Royal Commission's Report was informed by a conceivable body of research commissioned from reputable bodies and individuals.<sup>831</sup> It covered

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<sup>830</sup> *A New contract for retirement*, by Richard Books, Sue Regan and Peter Robinson. The modelling for the IPPR was carried out by the PSSRU at the London School of Economics and the Nuffield Community Care Studies Unit at the University of Leicester.

<sup>831</sup> Including researchers at the Department of Health, Social Community Planning Research, the Policy Research Institute on Ageing and Ethnicity, Universities of Leeds, Leicester, Manchester, Nottingham and PSSRU.

such key topics as costs, the scope for private insurance, international experience of funding regimes, recent developments in community care policy and alternative models of care.

#### A2.8.4 Further Reflections

42. It is true that some 70% of older people in long-term care get some state help with the costs. Many of these people will have had to use their not necessarily large capital, including the proceeds of selling their house, and so suffer the indignity of being reduced to penury before state support kicks in. Even now, people with capital of £18,500 get no state help with any care costs, except in Scotland. This is hardly a vast sum, especially for a system largely reliant on means-testing. A report published in 2002 showed that 61% of self-funders in nursing and residential care had incomes under £200 a week.<sup>832</sup> 70% of residents had assets of £16,000 (the previous upper limit) but were struggling to meet the weekly charges. There is, therefore, no question of the Royal Commission's proposal being just some form of unnecessary handout to the rich.
45. It is true that the Royal Commission itself recommended free nursing care (only) as an option with 'much merit'. This recommendation was one of a series which we saw as steps along the road to the key proposal that all personal care should be free. It corrects an anomaly in the NHS under which care provided by nurses in hospitals and GP practices was free, but nursing

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<sup>832</sup> Department of Work and Pensions

care in residential settings was not. It is a modest step along the road to a just and principled solution, but by no means a sufficient answer to the care funding problem.

#### A2.8.5 The Way Forward

47. There is clearly a need for restraint in public spending and for limits on what taxpayers can be expected to pay. The Commission's recommendation took full account of this. At the same time in recent years many additional £billion have been allocated to the public services and to the NHS in particular, according to some without securing much visible improvement. In comparison to this, the £1.1 billion gross annual cost of free personal care is modest, and would deliver. It cannot make sense to assert that this sum is not affordable. It patently is. The predicted 2.5% annual growth in GDP used in the Royal Commission's Report on Treasury advice may now be overoptimistic, but this does not invalidate our judgement. The Treasury's recently published Long-Term Public Finance Report suggests that, assuming no change in current policies, spending on long-term care and the health needs of older people may actually fall in relative terms over the next 50 years.

#### A2.8.6 Conclusion

50. In the light of the analysis and reflections in this Statement, as Royal Commissioners we:

- (1) Request the four Governments to re-consider the Commission's proposal for a National Care Commission.
- (2) Express the hope that there will be faster progress towards pooled budgets and care need assessments.
- (3) Re-affirm the recommendation that both nursing and personal care should in principle be free at the point of use, in both residential and domestic settings.
- (4) Welcome the decision of the Scottish Executive to implement this proposal.
- (5) Recommend the English, Welsh and Northern Ireland Governments to move to speedy implementation, phased if necessary.
- (6) Encourage the undertaking of research into the relative impact of the care-funding systems and related issues.
- (7) Call on Members of Parliament, organisations and individuals concerned with the care of older people, including the Right to Care Campaign, to renew their efforts to promote the implementation of the Royal Commission's recommendation.

- (8) Declare that we will continue to press the case for our recommendation on the grounds that it is a just, principled and affordable way of meeting a pressing social need.

#### A2.9 Signatories to the Statement

Lord Sutherland of Houndwood chaired the Royal Commission. He was Principal and Vice-Chancellor of Edinburgh University, and is now Warden of Gresham College and Chairman of English Care.

Dame June Clark is Professor of Community Nursing at Swansea University and a former President of the Royal College of Nursing.

Sir Nicholas Goodison is a former Chairman of the London Stock Exchange and of the TSB Group, Deputy Chairman of Lloyds TSB and British Steel, and has also been Chairman of a number of prominent arts organisations.

Dr Iona Heath is a General Practitioner in North London and Chair of the Ethics Committee and of the Health Inequalities Standing Group at the Royal College of General Practitioners.

Professor Mary Marshall is Director of the Dementia Services Development Centre at the University of Stirling.

Claire Rayner is a writer, broadcaster and novelist, a former nurse and a former Chair of the Patients' Association.

Paula Ridley is Chair of the Liverpool Housing Action Trust and of the Trustees of the Victoria and Albert Museum, and Director of the Calouste Gulbenkian Foundation.

Professor Robert Stout is Professor of Geriatric Medicine at Queen's University Belfast, Director of Research and Development for the Northern Ireland Health and Personal Social Services, and President of the British Geriatrics Society.

Robin Wendt is a former senior official of the DHSS and in Local Government, and current Vice-Chair of the Cheshire and Merseyside Strategic Health Authority."

## APPENDIX 3

### Extracts – Report of the Mid Staffordshire NHS Foundation Trust

#### Public Enquiry Executive Summary by Robert Francis QC – (6 February 2013) – HC 947

- “1. In 2007 concerns were raised about the Trust’s mortality rate compared with other similar trusts. Then in April 2008 the HCC launched an investigation into the Trust.....In March 2009 it published the report of its investigation, which was highly critical of the acute care provided by the Trust.
2. The culture of the Trust was not conducive to providing good care.....there was an atmosphere of fear of adverse repercussions; a high priority was placed on the achievement of targets; the consultant body largely dissociated itself from management; there was low morale amongst staff; there was a lack of openness and an acceptance of poor standards.
3. Management thinking.....was dominated by financial pressures and achieving Foundation Trust (FT) status, to the detriment of the quality of care. There was a management failure to remedy the deficiencies in staff and governance, including an absence of effective clinical governance ...Statistics and reports were preferred to patient experience data, with a focus on systems, not outcomes.



4. The Trust's culture was one of self-promotion.....seen from the way the Trust approached its FT application, its approach to high Hospital Standardised Mortality Ratios (HSMR's) and its inaccurate self-declaration of its own performance.
5. Consultants at Stafford were not at the forefront of promoting change.....Clinicians did not pursue management with any vigour with concerns they might have had. Many kept their heads down.
6. I have no doubt that the economies imposed on the Trust Board, year after year, had a profound effect on the organisation's ability to deliver a safe and effective service.
7. There was an unacceptable delay in addressing the issue of shortage of skilled nursing staff.....The slowness of the Board to inject the necessary funds and a sense of real urgency into the process, was the priority given to ensuring that the Trust books were in order for the FT application.
8. As a result of poor leadership and staffing policies, a completely inadequate standard of nursing was offered on some wards at Stafford.....inadequate staffing levels....poor leadership, recruitment and training. This led in turn to a declining professionalism and a tolerance of poor standards.

9. The erroneous authorisation of the Trust as an FT came about almost entirely because the HCC and Monitor were separate organisations, going about their regulatory business without coordinating their activities with each other.....The HCC had little by way of financial expertise available to it, and Monitor, likewise, little clinical resource.....This communication failure may in part have been as a result of Monitor fiercely guarding its independence, at the expense of fostering good relationships with others.
10. Monitor did not formally decide that the Trust was in significant breach of its authorisation until after the publication of the HCC report. However, it had been aware since at least May 2008 that there was a likelihood that it was in significant breach. The view of Monitor's senior management that it should wait for the HCC's final report.....The reasoning adopted was flawed. It could have, but did not, request the HCC to furnish it with an interim report presenting the evidence and any recommendations that Monitor believed to be lacking.....Monitor retained its own statutory responsibility and judgement, as well as the power of intervention. Insofar as it exercised these, it did so with undue delay.
11. At the heart of the failure (of the HCC) to detect or prevent the appalling events at Stafford sooner was the concept of the core standards and the means of assessing compliance: the annual health check (AHC). The core standards suffered from a number of deficiencies.....Generic standards were formulated not by the regulator but.....by the Department of Health (DH).....contributing to the impression that that the process was Government

controlled and thereby reinforced the disengagement of frontline clinicians from a concept, which if it was to work, demanded their involvement and endorsement.....The assessment process also suffered a number of defects. Principal among them was the reliance on self-assessment and self-declaration as the basis of regulation.

12. The CQC has had many challenges since its inception.....The evidence does give the impression that strategy has to some extent been driven by a perceived need to fit the activity of the organisation to the resources available.....The Inquiry has seen evidence of a defensive institutional instinct to attack those who criticise it, however honestly and reasonably those criticisms are made.....Whilst ...work has obviously gone into matching the outcomes in the essential standards with the regulations, there is a lack of clarity which derives from the regulations combining in one regulatory requirement a number of different concepts, such as “safety” and “welfare”. These are requirements which have to be met but are not necessarily given very much attention as statutory obligations in day-to-day clinical work.....The impression is that patient information and feedback are not priorities.....when the CQC is considering its regulatory approach. It is service users, including visitors and families, who are likely to be the first to witness poor outcomes or the warning signs that standards are slipping.”<sup>833</sup>

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<sup>833</sup> Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry (6 February 2013) HC947 Ibid. – Executive Summary Pages 11-58.

## APPENDIX 4

### EXTRACTS – “HOUSE OF LORDS – SELECT COMMITTEE ON PUBLIC SERVICE AND DEMOGRAPHIC CHANGE – REPORT OF SESSION 2012-13 – READY FOR AGEING? – REPORT – PUBLISHED 14 MARCH 2013 – HL PAPER 140”

#### A4.1 Introduction

1. The UK population is ageing rapidly but we have concluded that the Government and our society are woefully underprepared. Longer lives can be a great benefit, but there has been a collective failure to address the implications and without urgent action this great boon could turn into a series of miserable crises.
2. The committee focussed on the implications of an ageing population for individuals and public policy in the near future, the decade 2020-2030. Key projections about ageing include:
  - 51% more people aged 65 and over in England<sup>834</sup> in 2030 compared to 2010
  - 101% more people aged 85 and over in England in 2030 compared to 2010<sup>835</sup>

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<sup>834</sup> Due to the effects of devolution, our focus is primarily on England, although many of the issues that we have highlighted may apply throughout the United Kingdom: see Annex 1.

<sup>835</sup> Central Government (Department of Health (DoH), Department for Work and Pensions (DWP) and Department for Communities and Local Government (DCLG)), written evidence. See Annex 2.

- 10.7 million people in Great Britain can currently expect inadequate retirement incomes<sup>836</sup>
  - Over 50% more people with three or more long-term in England by 2018 compared to 2008<sup>837</sup>
  - Over 80% more people aged 65 or over with dementia (moderate or severe cognitive impairment) in England and Wales by 2030 compared to 2010<sup>838</sup>
3. Longer lives represent progress, and the changes do not mean a great economic or general fiscal crisis.\* Moreover the contribution to our society made by older people, which is already impressive, will be even greater as a result:

Others have looked at aspects of these changes, but the Committee's approach was holistic:

Surveying the landscape to highlight key issues for our society and encourage public debate.

- 4. To make a success of these demographic shifts, major changes are needed in our attitudes to ageing.
- 5. The National Health Service will have to transform to deal with very large increases in demand for and costs of health and social care. Overall the quality of healthcare for older people is not good enough now.

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<sup>836</sup> Department for Work and Pensions, *Estimates of the number of people facing inadequate retirement incomes*, July 2012.

<sup>837</sup> The King's Fund, Supplementary written evidence.

<sup>838</sup> Professor Carol Jagger, Newcastle University.

6. Social care and its funding are already in crisis, and this will become worse as demand markedly increases. The split between healthcare and Social care is unsustainable and will remain so unless the two are integrated.
7. An ageing society affects everyone: these issues require open debate and leadership by the Government and all political parties. The challenges are by no means insuperable, but no Government so far has had a vision and coherent strategy.

### *Later working*

By 2030, men aged 65 in the UK will expect to live another 23 years, to 88, and women another 26 years, to 91.<sup>839</sup>

### *Reforming Pensions and Savings*

12. The UK has a worrying under-saving problem.<sup>840</sup>

The Committee has concluded:

- The Government were right to raise the state pension age, but they are now adopting a timetable of increases slower than that recommended by the Turner Commission and will have to revisit this with rising healthy life expectancy. Those who work beyond state pension age should clearly benefit if they defer taking their pension.
- Auto-enrolment is a big step forward for people who would otherwise not be saving for a pension. However, while helpful, auto-enrolment alone will not solve the problem of under-saving.

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<sup>839</sup> Office for National Statistics (ONS) *m Pension Trends – Chapter 2: Population change*, February 2012, data for figure 2.5.

<sup>840</sup> Department for Work and Pensions, *Estimates of the number of people facing inadequate retirement incomes*, July 2012.

- But saving more is made less likely as the current defined contribution pension systems is not fit for purpose for anyone who is not rich, or who moves in and out of work due to bad health or the need to care for others.

The Committee urges the Government, pensions industry and employers to tackle the lack of certainty in defined contribution pensions and address their serious defects to make it clearer what people can expect to get from their pension as a result of the savings they make.

#### *Using the value in our homes*

People with housing equity should be enabled to release it simply, without excessive charges or risk. The Government should work with the financial services industry to ensure such mechanisms are available, and to improve confidence in them.

#### *Living independently and well*

Older people are diverse; most enjoy life and want to live independently, in their own home for as long as possible. But eventually almost all of us will need healthcare.

#### *Increasing pressures on health and social care*

The NHS is facing a major increase in demand and cost consequent on ageing and will have to transform to deal with this. Because of this rising demand, without radical changes in the way that health and social care serve the population, needs will remain unmet and cost pressures will rise inexorably.

The committee has concluded that the current healthcare system is not delivering good enough healthcare for older people and is inefficient; there is an urgent need to change the current system to provide better healthcare more efficiently and this should help with the predicted funding shortfall.

Social Care funding is already in crisis, and this will become worse as demand markedly increases. Many people needing social care now are not getting it as eligibility thresholds are tightened because of reduced local authority funding (see Annex 10). The Government's response to the proposals made by the Commission on Funding of Care and Support (the Dilnot Commission) is welcome and necessary but in our view will not be sufficient because it will largely benefit higher income groups by protecting them from depleting their housing assets rather than address the current funding crisis (see Annex 11). It does not bring extra funding into the system to tackle the current funding crisis or address the problem of expanding need in the coming decades – although we acknowledge that this was not the task given to the Commission.

To meet the needs of the population, and to achieve this shift in services, the health and social care system needs to work well 24 hours a day, seven days a week.

The inter-dependent nature of health and social care means that the structural and budgetary split between them is not sustainable: healthcare and social care must be commissioned and funded jointly, so that professionals can work together more effectively and resources can be used more efficiently. The Government and all political parties will need to rethink this issue.



The Government must set out the framework for radically transformed healthcare to care for our ageing population before the general election in 2015. All political parties should be expected to issue position papers on the future of health and social care within 18 months, and address these issues explicitly in their manifestos for the 2015 Election.

Central and local government should work together with the third sector to increase volunteering especially by older people to support older people.

#### A4.2 Fairness

It does not seem fair to expect today's younger taxpayers – especially those not born to better-off parents – to pay more for the increased costs of an older society while asset-rich older people (and their children) are protected.

So the Government elected in 2015 should, within six months, establish two commissions based on cross-party consultations: one to work with employers and financial services providers to examine how to improve pensions, savings and equity release, and one to analyse how the health and social care system and its funding should be changed to serve the needs of our ageing population. Both commissions should be required to report within 12 months and to make clear recommendations for urgent implementation.

#### A4.3 Principal conclusions and recommendations

The Committee urges the Government, pensions industry and employers to tackle the lack of certainty in defined contributions pensions and address their serious defects to make it clearer what people can expect.

People with housing equity should be enabled to release it simply, without excessive charges or risk. The Government should work with the financial services industry to ensure such mechanisms are available, and to improve confidence in them (paragraph 17).

The inter-dependent nature of health and social care means that the structural and budgetary split between them is not sustainable:

Central and local government, housing associations and house builders need urgently to plan how to ensure that the housing needs of the older population are better addressed.

Our focus has been on the impact of ageing on public services in the medium term, looking ahead to 2020 and to 2030.

## ANNEX 6: WHY INDIVIDUALS, MARKETS AND GOVERNMENTS FAIL TO PREPARE ADEQUATELY FOR AGEING (RELEVANT THROUGHOUT THE REPORT)

### A4.4 Market failures

Although an insurer may know the likelihood that a person entering care today will stay for a certain length of time, such probabilities might change substantially over the period of an insurance contract, especially if the contract is entered into prudently early. Medical progress might reduce the likelihood of people developing dementia, for example, but separate medical advances might increase the likelihood of an individual surviving disease but in a disable state, with their care costs rising sharply as a result. These factors make insurers very reluctant to offer long-term care products, with the result that makes for elderly people's healthcare insurance tend to be unaffordable.

### A4.5 Government failure

The Committee heard how democratic governments are ill-equipped for long-term, joined-up thinking on this issue.

The incapacity of individuals and the markets to be able to respond efficiently to an ageing future has been exacerbated by a coterminous failure by the state to adapt its institutions. The Government have begun to respond with the help of independent reviews like those conducted by the Turner and Dilnot Commissions.

## A4.6 ANNEX 7: FAIRNESS BETWEEN AND WITHIN GENERATIONS

As society ages and demands more spending on the elderly, our society must avoid unfairly shunting the costs on to future generations. So it is important to ensure that those who are benefiting from longer lives pick up at least part of the tab.

### A fair deal between generations

It is reasonable to expect those who have benefited from the property boom to support their own longer lives. We suggest that one way to address the current imbalance would be for more older people to consider unlocking housing wealth.

## A4.7 ANNEX 8: PENSIONS AND SAVINGS

### Pension problems

While the defined benefit pensions system has proved to be unsustainable, we consider that for many savers defined contribution pensions are seriously inadequate.

### Policy responses

The Government are taking positive steps in pension reform, and when complete, the current reforms to the pensions system will represent progress, which the Committee welcomes.

The Committee concludes that despite significant progress, the current system of state and private pension provision is still not adequate for a large proportion of the future elderly population. While progress is being made on state

pensions, we conclude that the current DC pensions system is not fit for purpose for anyone who is not rich, or who moves in and out of work due to bad health or the need to care for others.

#### A4.8 ANNEX 10: FUNDING PRESSURES ON HEALTH AND SOCIAL CARE

If the current healthcare system did not change and the large NHS funding gaps for 2021/22 estimated by the Nuffield Trust materialised, this would have particularly serious consequences for older people, as the biggest consumers of NHS spending. The NHS will have to be transformed, in service delivery terms, in order to deal with changing needs more efficiently; this transformation should help with the predicted funding shortfall.

Eighty-five per cent of English councils are now implementing a threshold at 'substantial' or 'critical' needs, resulting in a growing level of unmet need, with people unable to access support until their needs reach crisis point.

There should be a sharing of responsibility for social care between individuals and the state, although on a basis that it's less worrying for older people, as the Dilnot Commission proposed (see Annex 11). But there are many people who do not have families who can provide care, or the money to buy it, but who cannot cope without care – and this situation is likely to worsen considerably with greatly increasing numbers needing such care in the coming years.

#### A4.9 ANNEX 12: HEALTH AND SOCIAL CARE: STRUCTURAL CHANGE?

The fundamental problem: the split between healthcare and social care

The barrier to integrated health and social care explored above, and the inter-dependent nature of health and social care, has driven the Committee to conclude that the structural and budgetary split between them is not sustainable. We urge the Government to accept that the structural split is a major obstacle to the effective and efficient delivery of the care our older society will need. Healthcare and social care must in the future be commissioned and funded jointly, so that professionals are enabled to work together more effectively and resources can be used more efficiently. Further major structural upheaval of the healthcare system at this point would be undesirable and counter-productive. However, we consider that the Government and all political parties will need to rethink this issue.

Encouraging innovation in the meantime

In the absence of counter-productive systemic change in the near future, and because full integration cannot be achieved immediately, there needs to be significant experimental work at the local level over the next five years. Local authorities and clinical commissioning groups must be allowed licence to experiment, and they must be pushed to innovate.

A4.10 ANNEX 13: HEALTH AND SOCIAL CARE: ADJUSTING TO CHANGING PATTERNS OF NEED

## Preventing unnecessary hospital admissions of older people

“There are a lot of older people who are in hospital whose admission would have been prevented had the care been better co-ordinated upstream”, and John Kennedy and Professor Paice agreed.

We agree with the Royal College of Physicians that the healthcare system must “ensure the availability of primary care services whenever they are needed, including at the weekend and at night”. We were pleased that the Secretary of State for Health, the Rt Hon Jeremy Hunt MP, agreed that “we have to have a 24/7 NHS”. We are heartened by his commitment to 24/7 health services, and we call on him within 12 months to set out how this will be made real. For this to have value, there will also have to be 24/7 community-based healthcare and social care.

We consider that the shift in the health and social care system away from acute and emergency services and towards preventing older people from going into hospital should also help with the funding pressures facing social care. Some of the funding released from acute and emergency services should flow into improving social care, as part of reducing the hospitalisation of older people who could be better treated in the community. We consider that health and social care integration is the longer-term solution for social care funding.

## The need for leadership

This vision for the long term must not be undermined by short-term budgetary cycles. The health and social care systems need to be enabled to plan more strategically and systematically for changing long-term needs. We conclude that the Government

should consider introducing a 10 – year spending envelope for the NHS and publicly-funded social care.

#### A4.11 ANNEX 14: HEALTH AND SOCIAL CARE: IMPROVING LOCAL CARE IN PRACTICE

##### Sharing data

If health and social care systems cannot easily share data about an individual, the result is inefficiencies, delays, duplications and suffering.

Some practitioners have made heroic efforts to join up the dots. North West London Integrated Care Pilots brought together data across organisational boundaries, it had to ask 24,000 people for their consent, and only 300 objected. In Torbay, the same computer system is being used across health and social care. An electronic palliative care co-ordination system in London has resulted in the number of people in the system who die in hospital falling to half what it is across the rest of London.

Enabling more data to be shared is crucial. Constraints must be removed, risk-averse attitudes must be reduced, and myths which result in people feeling unnecessarily restricted must be challenged. If necessary, legislation must be introduced.

##### Opening up the social care sector



Steve McIntosh, Policy and Public Affairs Manager, Carers UK and Martin Green, Chief Executive, English Community Care Association, both regretted that the Care Quality Commission (CQC) does not provide star ratings for care services.

The Secretary of State for Health confirmed that he would “like to introduce Ofsted-style ratings across the care home sector, across hospitals, across GP surgeries, the works” as long as it was done in a way that was academically and clinically rigorous.

#### Spreading good practice

We congratulate heroic professionals such as those in Torbay and the North West London Integrated Care Pilots who are striving to make the poor system function. Innovative experiences need to be learned from, shared and copied.

#### A4.12 ANNEX 18: STRATEGIC PLANNING, KEY CHOICES AND POLITICAL LEADERSHIP

Given the short-term nature of electoral and budgetary cycles, there are very weak political incentives for long-term thinking in the formulation of government policy. Governments have been better at acting to limit their exposure to increasing costs as a result of ageing, such as in the field of pensions, than planning for improvements in the quality of the services that they deliver commission for support.

The Committee was disappointed to find how little the Government have done to initiate a long-term, coherent strategy to deal with the consequences of population ageing.

#### Demonstrating political leadership

This White Paper would set out their vision for future public service delivery against the background of the ageing population.

Progress will not be made if the solutions chosen by the Government change with each administration.

## APPENDIX 5: CALL FOR EVIDENCE

### APPENDIX

#### A. What challenges will an ageing population pose?

- 1) The population projections from the office for National Statistics show the very significant growth of the older population, and there will be many social benefits from this. But the OBRs recent fiscal sustainability report, July 2012, forecasts a worsening fiscal deficit as a consequence. Do these forecasts capture the challenges or underestimate them?

- 2) If life expectancy rises further but healthy or disability free life expectancy does not there will be costs for health and social care, for state pensions and for public sector pensions. Are these risks and costs adequately shared?
  - 3) Raising productivity in the NHS and in public services generally is fundamental to coping with the immediate fiscal challenge. Do you think it will happen? If not what are the implications for the coming demographic challenges?
  - 4) What will an ageing society be like? What might this imply for individuals, families, and communities? What are the implications for individuals' capacity to work longer and live independent lives, and for productivity, competitiveness and inequality?
  - 5) Do the additional fiscal deficits caused by an ageing society, the increased demand for services and better outcomes require a radical re-think by central and local government and the NHS to prepare and change to address them? What should be done?
- B. What strategic choices need to be addressed?
- 6) There are many benefits from an ageing population, but growing public sector demands and a growing fiscal challenge are consequences too. If society will not accept substantial tax increases what are the big choices for what the state does and what individuals do? Who should pay for what?

- 7) The increasing cost of an ageing population could put great pressure on expenditure on other priorities and investment. Will free health services, improved social care and decent state pensions all be affordable? What are the choices?
- 8) We will be better off in the future but there will still be a need to re-shape our expectations and our welfare state for an ageing population. Which attitudes and expectations need to change about our welfare state, about retirement, the age of retirement and inheritance?
- 9) Do we need greater clarity about what the state will and will not fund for the future, and a more explicit contract between the state and individuals? What should this be?
- 10) Do the dates when the state pension age rises reflect these coming changes? Are the risks and costs of public sector pensions shared fairly between beneficiaries and taxpayers?
- 11) How might inter-generational fairness be achieved? If we need to encourage younger people to save more for their own retirement, their social care and their higher education, can they also pay more taxes for an ageing population?
- 12) How are countries with similar ageing populations adapting?

*What reforms to public actions are needed?*

- 13) The additional demands and fiscal challenges caused by an ageing society, plus dissatisfaction with current services and outcome, require all public services to change for the better. Is it happening? If not what must be done?
- 14) Fundamental service re-designs may be needed. What might be the principles behind such re-design and are there attitudinal, structural and cultural impediments to making them happen such as silo structures and budgets, lack of preventative actions?
- 15) Where is it important for the state to reduce demand or transform its actions? Should we look at where expenditure is high yet outcomes are poor such as the management of long term conditions?
- 16) Which preventative programmes are most needed? Could new funding mechanisms such as social impact bonds make this happen?

*Older People*

- 17) How good are current services for older people? Services for older people are highly fragmented and subject to unhelpful financial incentives. What evidence is there of good practice in resolving these issues in the UK or abroad?

- 18) How should labour markets, employment law and practices change to enable older people to work?
- 19) How might Government best stimulate and regulate markets to respond to the varied risks faced by vulnerable elderly people? What are the limits to such markets?
- 20) How can public actions help extend individuals' health and independence in older age? How can voluntary and community actions contribute more? How should housing services change better to support independent older living?
- 21) Funding constraints have already squeezed the resources available to private providers of long term care and NHS geriatric care. There have been concerns about standards in all sectors. What more should be done to improve standards and public confidence?
- 22) Addressing these challenges requires public debate about choices, attitudes and expectations. How can this happen? How can the public be stimulated to address the likelihood that they will live longer?
- 23) What should central government and local government and the NHS be doing now to address these challenges?

- 24) Changes to state priorities and efficacy for the medium term should arguably be significant considerations in the next public spending round. Is this happening?

The deadline for written evidence is 1 September 2012.

## APPENDIX 6

### EXTRACTS – CARE ACT 2014 (CHAPTER 23)

(ROYAL ASSENT – 14 MAY 2014)

#### PART 1 – Care and Support

##### General responsibilities of local authorities

Section 1 - Promoting individual well-being.

Section 3 - Promoting integration of care and support with health services etc.

Section 4 - Promoting information and advice.

Section 6 - Co-operating generally.

##### Assessing needs

Section 9 - Assessment of an adult's needs for care and support.

Section 10 - Assessment of a carer's needs for support.

##### Charging and assessing financial resources



Section 14 - Power of local authority to charge.

Section 15 - Cap on care costs.

Next steps after assessments

Section 24 - The steps for the local authority to take.

Section 25 - Care and support plan, support plan.

Section 26 - Personal budget.

Section 28 - Independent personal budget.

Deferred payment agreements, etc

Section 34 - Deferred payment agreements and loans.

Safeguarding adults at risk of abuse or neglect

Section 42 - Enquiry by local authority.

Section 43 - Safeguarding Adults Boards.

Provider failure

Section 48 - Temporary duty on local authority.

## Market oversight

Section 53 - Specifying criteria for application of market oversight regime.

Section 54 - Determining whether criteria apply to care provider.

Section 55 - Assessment of financial sustainability of care provider.

## Independent advocacy support

Section 67 - Involvement in assessments, plans etc.

Section 68 - Safeguarding enquiries and reviews.

## Miscellaneous

Section 73 - Human Rights Act 1998: provision of regulated care or support etc. a public function.

## Part 2 – Care Standards

### Quality of services

Section 81 - Duty of candour.

Section 83 - Imposition of licence conditions on HNS foundation trusts.

Section 84 - Trust special administration: appointment of administrator.

## Care Quality Commission

Section 88 - Unitary board.

## Increasing the independence of the Care Quality Commission

Section 90 - Independence of the Care Quality Commission.

## Performance ratings

Section 91 - Reviews and performance assessments.

## Regulated activities

Section 95 - Training for persons working in regulated activity.

## Establishment

Section 96 - Health Education England.

## National functions

Section 97 - Planning education and training for health care workers etc.

Section 98 - Ensuring sufficient skilled health care workers for the health service.

## Chapter 2 – Health Research Authority

### Establishment

Section 109 - The Health Research Authority.

## Patient Information

Section 117 - Approval for processing confidential patient information.

#### Chapter 4 – Trust special administration

Section 120 - Powers of administrator etc.

#### Part 4 – Health and Social Care

##### Integration fund

Section 121 - Integration of care and support with health services etc integration fund.

Section 127 - Commencement

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ADASS:	Association of Directors of Adult Social Services
BMA:	British Medical Association
C&C:	Command and Control (class of regulation)
CHAI:	Commission for Healthcare Audit and Inspection (the Healthcare Commission)
CHI:	Commission for Health Improvement
CHRE:	Council for Healthcare Regulatory Excellence
CQC:	Care Quality Commission
CSCI:	Commission for Social Care Inspection
GMC:	General Medical Council
HCC:	Healthcare Commission
IFS:	Institute for Fiscal Studies
IPPR:	Institute for Public Policy Research
IRA:	Independent Regulatory Agencies
LGA:	Local Government Association
NCSC:	National Care Standards Commission
NHS:	National Health Service
NICE:	National Institute for Clinical Excellence
NMC:	Nursing and Midwifery Council

NMI	Non-ministerial Institutions
OBR:	Office for Budget Responsibility (HM Treasury)
ONS:	Office for National Statistics
PCT:	Primary Care Trust
PSA:	Professional Standards Authority
RCS (Eng):	Royal College of Surgeons of England
RCN:	Royal College of Nursing
RCP:	Royal College of Physicians
RGN:	Registered General Nurse
RHA:	Regional Health Authority
SEN:	State Enrolled Nurse
SHA:	Strategic Health Authority
SRN:	State Registered Nurse
SRO:	Self-Regulatory Organisation

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